the Canadian Nurse

VOLUME 60 • NUMBER 10

MONTREAL

OCTOBER 1964

IMPROVEMENT OF NURSING PRACTICE

ABDOMINOPERINEAL RESECTION AND NURSING CARE

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Between Ourselves

For the first time in nearly a decade, the name of JEAN ELIZABETH MACGREGOR is missing from the roster of editorial staff members that appears regularly in each issue. Perhaps you suspected some changes were imminent when the advertisement for assistant editors, both English and French, appeared in the *Journal* last April. We will introduce both GLENNIS ZILM and MARGUERITE MORIN to you next month, but today, we at the *Journal* are bidding farewell to our long-time associate.



JEAN E. MACGREGOR

A graduate of Royal Victoria Hospital, Montreal, with her Bachelor of Nursing degree from the McGill School for Graduate Nurses, her Bachelor of Arts from Sir George Williams University, Jean joined the editorial staff in 1955. She has left us to return to McGill where she is presently enrolled in the course leading to her bachelor's degree in library science. Though we shall miss her greatly we know we speak for all of you when we wish her much happiness and continued success in the new field she is about to enter.

* * *

The excellent address that Miss MARGARET MCLEAN delivered at the biennial convention is featured in this issue. So much attention is focused on nursing education — its improvement, its extension to include advanced postgraduate degree work — that it is essential for us to remind ourselves that we must not minimize the significance of the "Importance of Nursing Practice." Miss McLean speaks with authority in discussing methods that will improve nursing service for she has had extensive experience in this area. Through her present work with the Department of National Health and Welfare she is in a strategic position to provide the kind of assistance that is so patently needed.

But no amount of talking, no widely publicized refresher courses, no actual demonstrations can produce the needed improvement if thousands of individual nurses do not feel a sense of commitment to do a better job in their immediate situation. When student nurses observe jobs being done with enthusiasm, with care and with resultant patient satisfaction, they themselves will adopt this commitment to nursing. A good example is the strongest influence in improving nursing practice.

* * *

Take a quick look at the captions your local newspaper has given the various news items. How many of them relate to catastrophes, calamities, disasters, uprisings, even wars? Tensions here, civil unrest there — oh, but it couldn't, wouldn't or doesn't happen in our town or our province or our country, you say.

Sometimes, unhappily, serious emergencies do occur in Canada. A fire, explosions, a crowded bus hit by a train — what does it take to jam hospital facilities? Why, or more importantly, how can any hospital, every hospital plan to handle any mass emergency that may occur? This is not civil defence in the sense of an atomic attack. It is preparing in advance for any eventuality, any crisis that may strike any community at any time. Be sure to read the considered statements of Dr. W. S. HACON and Miss EVELYN PEPPER. They know, from past experience, that too few hospitals in Canada are ready to handle any emergency that may arise.

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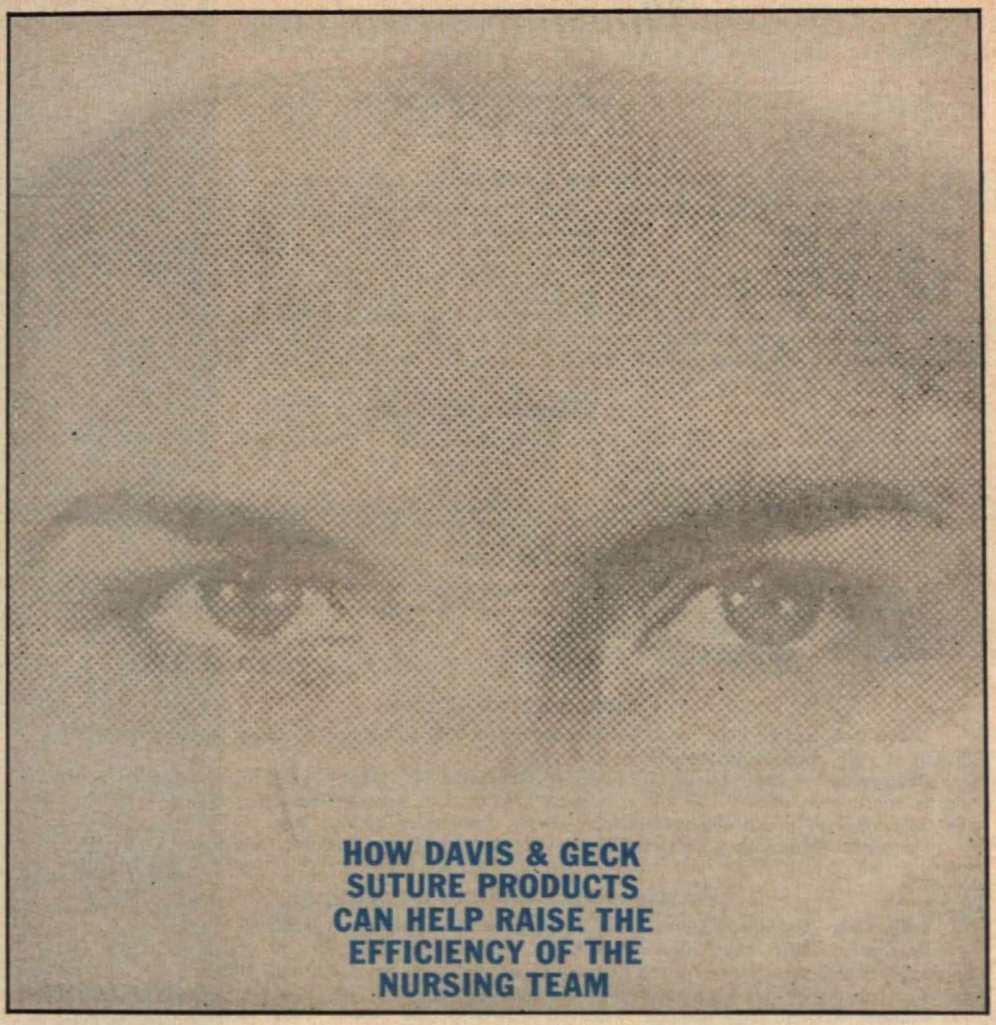
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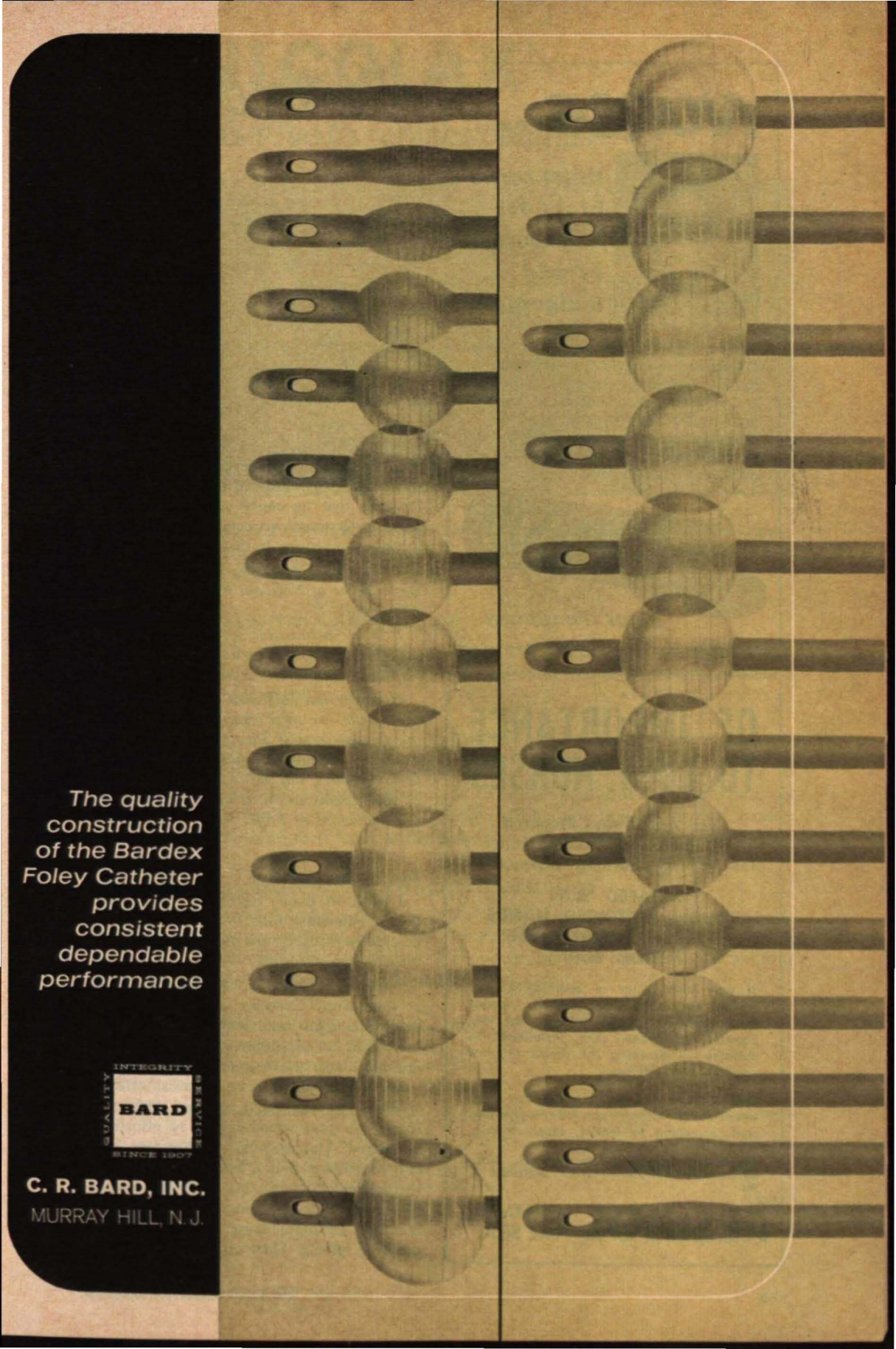
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Random Comments

Dear Editor:

Will you please publish the following announcement:

Coming in 1966 — Diamond Jubilee We are anxious to obtain the names (maiden and married) and address of graduates of the General Hospital school of nursing, St. John's, Newfoundland. Please forward to the undersigned at: Nurses' Residence, General Hospital, St. John's, Nfld.

JOYCE MACKAY

Dear Editor:

My husband was recently informed by the Taxation Division of the Department of Revenue that he could not deduct my annual professional association dues in his income tax return. Is this correct? R.N.

¶ *The Chief Assessor, Taxation Division, Department of National Revenue, replied to this query:*

It is not permissible for a husband to deduct his wife's annual dues paid to a professional association in his return.

If a wife has sufficient income to require her to file her own return, she may deduct the annual dues if she is claiming medical expenses, charitable donations and/or professional dues, but she may not deduct any of these items if she is claiming the standard deduction of $100. *Ed.*

Dear Editor:

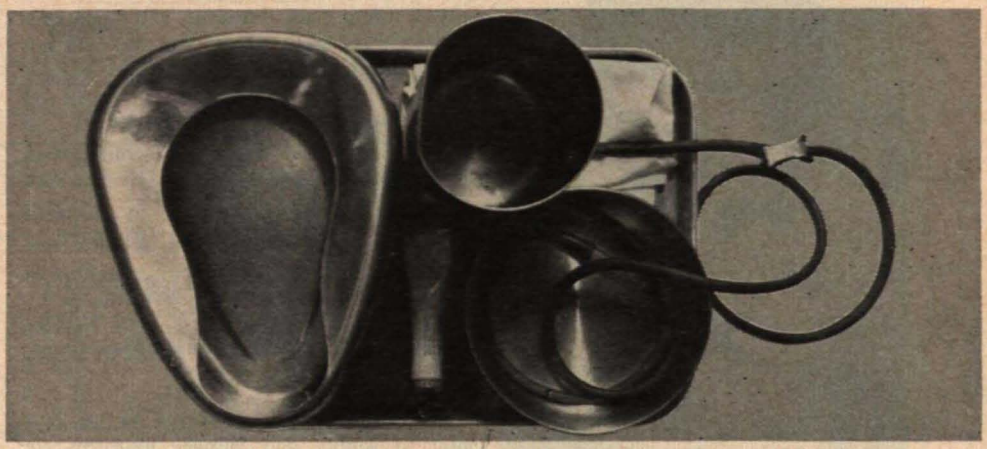
I wish to thank Helen M. King, (Random Comments, July 1964) for expressing so clearly many of my own thoughts on the question of uniforms.

I feel that the axiom "actions speak louder than words" applies, and that a nurse's dress proclaims her mental outlook. I use the word *dress* because graduate nurses are no longer clothed uniformly on duty.

We are supposed to be practical, efficient women, yet what could be more impractical than a uniform which cannot be effectively laundered? Our hospital supplies free laundry service, yet only a few staff nurses avail themselves of this facility. Only the director of nurses, the teaching staff, and three members of the nursing service office use this free service. Their uniforms never leave

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the hospital since they change their clothes in the locker rooms or in residence.

Many nurses and aides travel in their uniforms — either in their own cars or by public transport. What is to be done when nurses flaunt both authority and their education? They know better, yet they will not use their knowledge. Why do they behave in this manner? Is it because they are too lazy to change in the locker room? Or is it because they allow themselves so little time to prepare for duty that they have to save minutes by dressing at home in uniform?

Perhaps there is a deeper significance. Are they clamoring for public attention by proclaiming their occupation? If this is so, before long the graduates may be walking around with lamps in their hands to signify their superiority to the aides.

Perhaps the only solution is for the hospital to supply and launder uniforms for aides and hope that the graduates get the message — Loud AND Clear.

ELEANOR G. PARKES, Quebec

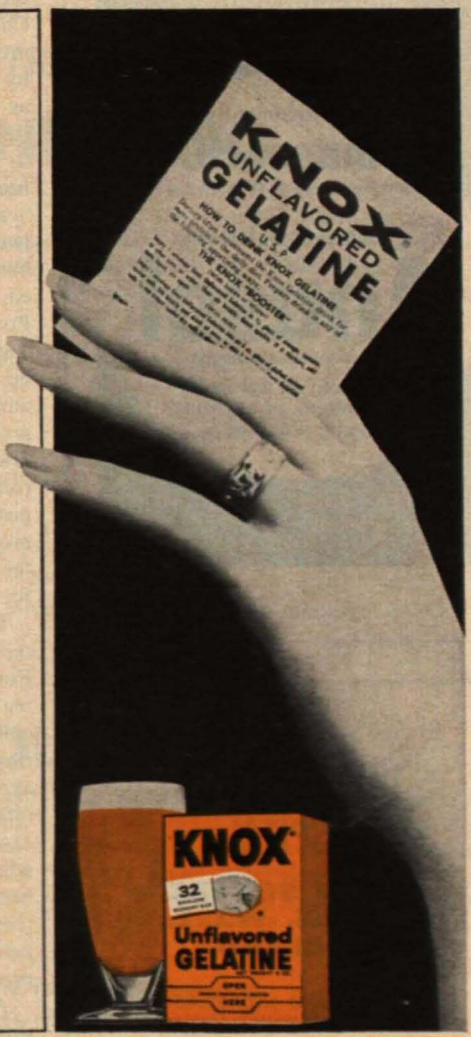
NEW HOPE FOR THE AMPUTEE

Two doctors, an engineer and a prosthetist watched closely as the man standing before them picked up a packet of cigarettes, opened it, withdrew one and lit it. Nothing very unusual about that, you might think — but the man was an amputee and the hand poised above the packet, the fingers that closed around it were powered by a tiny motor. The motor was triggered by stimuli from muscles in the upper arm that were in contact with twin electrodes. The group standing about the patient were witnessing another mark of man's ingenuity in overcoming his disabilities.

Dr. G. Gingras, executive director, Dr. M. Mongeau, chief of service — Physical Medicine and Rehabilitation, Mr. A. Lippay, consultant engineer, and Mr. C. Corriveau, consultant prosthetist, all from the Rehabilitation Institute of Montreal, visited the United Kingdom and Russia recently to obtain first hand information on the new artificial arm designed and developed by Soviet workers. Other countries, including England, had been working on a similar type of prosthesis but this was the first time that it had reached the stage of practical use.

How long should a patient maintain the Knox regimen to restore strength and beauty to fingernails?

When patients seek help for brittle, splitting fingernails, the chances are you will recall the Knox Gelatine regimen. It is important, however, for patients to understand that fingernail restoration is not an overnight process. Published data[1-5] have shown that about 90 days is the median time for replacement. Some patients will see faster results, in others a longer period of use is required. In any event, the need for continuing after the nail has grown out must be emphasized. The studies show how Knox works for 8 out of 10 patients, when followed as specified (one full envelope each day). There is evidence that capsule doses, of less than 7 grams per day, have little or no value. Patients who "Start with and stay with Knox" will see far more satisfactory results.

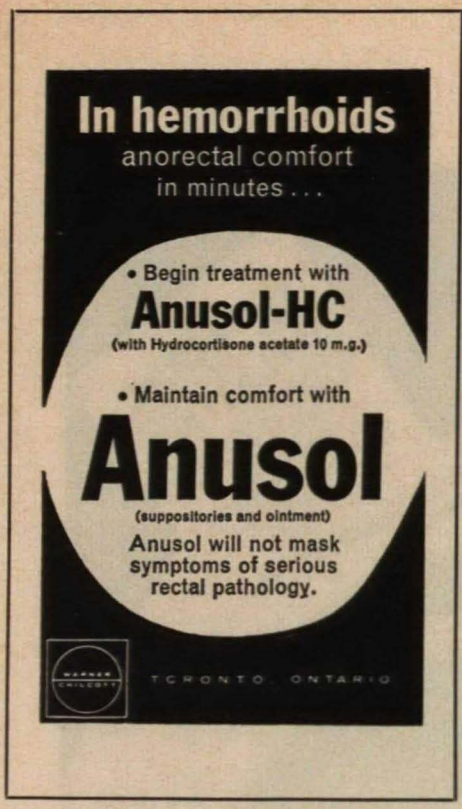


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- ☐ 1. Rosenberg, S., Oster, K. A., Kallos, A. and Burroughs, W.: A.M.A. Arch. Dermat. **76**:330, September, 1957.
- ☐ 2. Derzavis, J. L. and Mulinos, M. G.: Med. Ann. D. C. **XXX**:133, March, 1961.
- ☐ 3. Schwinner, M. and Mulinos, M. G.: Antibiot., Med. & Clin. Therapy **4**:403, July, 1957.
- ☐ 4. Rosenberg, S. and Oster, K. S.: Conn. State Med. J. **19**:171, March, 1955.
- ☐ 5. Tyson, T. L.: J. Invest, Dermat. **14**:323, May, 1950.

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The right to manufacture the arm in the United Kingdom has been purchased by the Lady Hoare Trust Fund as the result of a generous contribution by an anonymous benefactor. Lady Hoare is the chairman of the British Trust Fund for Thalidomide Children. Dr. Gingras and his colleagues, preoccupied with the problems to be faced by Canadian thalidomide-deformed children as they reach school age, are hopeful that the financial means to purchase the right to manufacture in Canada will somehow be found.

At present, the Soviet prosthesis offers two motions — opening and closing the hand. Laboratory demonstrations witnessed by the Montreal team at the Central Prosthetic Research Institute in Moscow, suggests that in a very short time it will be possible to use more muscles above the amputation site as triggers. Russian scientists are working towards the development of an arm with individual finger motions, wrist rotation, elbow flexion and extension, and possibly even shoulder motion. The present prosthesis is designed for adults but with the necessary adjustments it would be ideal for use by deformed or amputee children.

Dr. Gingras and his team met with representatives of the U.S.S.R. Ministry of Foreign Trade licensing bureau. The Ministry is interested and ready to discuss financial arrangements in order to grant the right to manufacture. In addition, such an agreement would provide for exchange of information as it becomes available and exchange of scientists. Manufacture in Canada would present no problems. The Rehabilitation Institute of Montreal has extensive prosthetic facilities and a highly experienced personnel who could produce the prosthesis easily.

Already some Canadians are beginning to show their appreciation of this development at the personal level. Contributions towards purchase of manufacturing rights have begun to reach the Institute. The total cost is reported to be around $30,000. The prosthesis would cost the patient around $300.

The second edition of *A Psychiatric Glossary*, prepared by the Committee on Public Information, American Psychiatric Association, is now available from Springer Publishing Company, Inc., 44 East 23rd. St., New York 10 N.Y. Price $1.00

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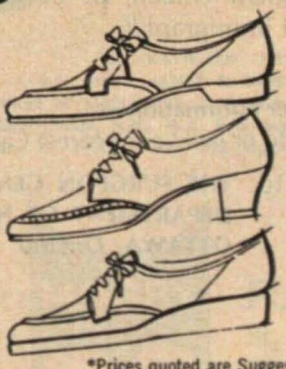


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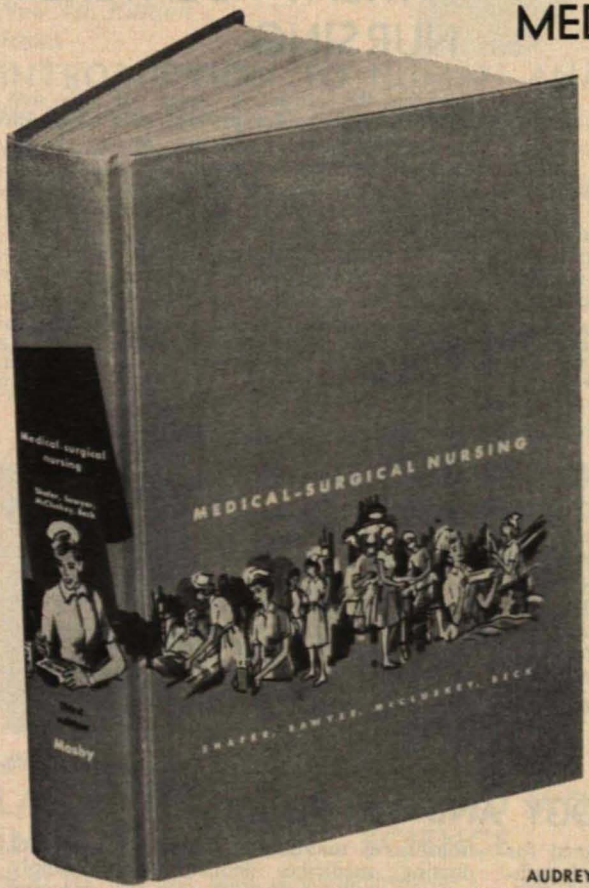
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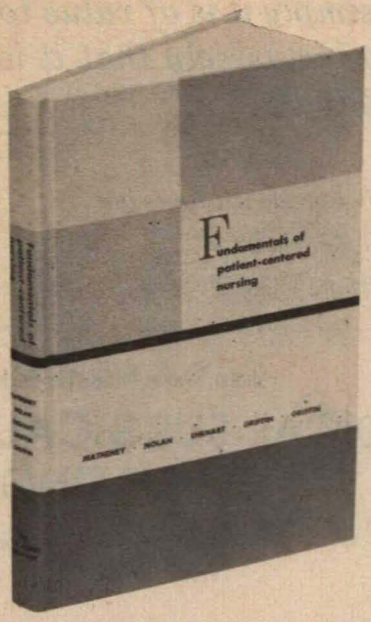
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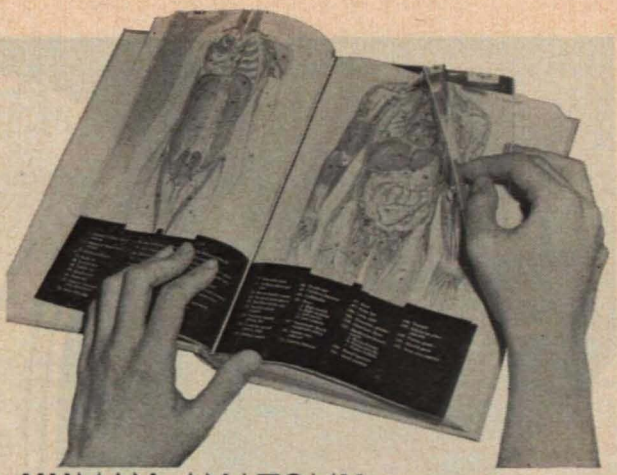
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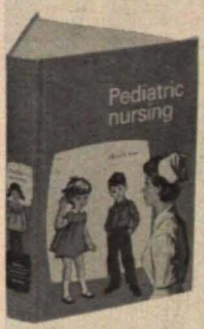
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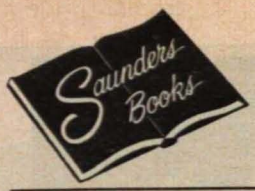
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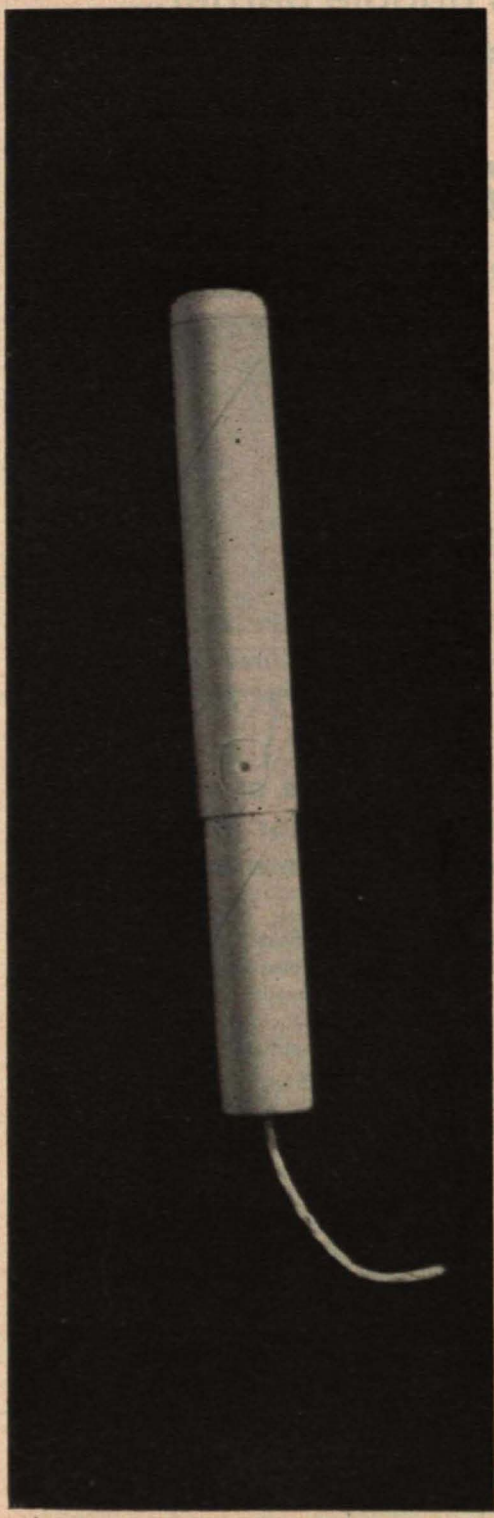
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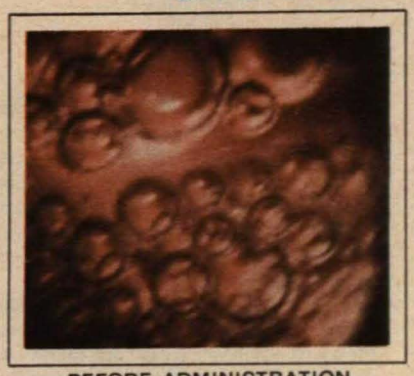
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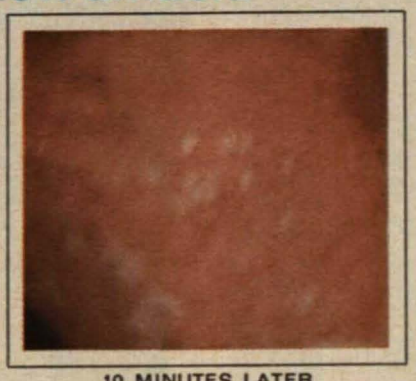
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BY THE CANADIAN NURSES' ASSOCIATION

VOLUME 60 MONTREAL, OCTOBER 1964 NUMBER 10

Improvement of Nursing Practice

The profession of nursing provides a service to people, consequently nursing practice affects people. We *know* this, but do we realize how many Canadians we affect? In 1961, 2,802,988 people (excluding the newborn) were admitted to general hospitals; 38,251 to mental health facilities; 13,924 to tuberculosis sanatoria. On any one day, there were 168,904 persons in hospitals. Added to these were those who received service from public health nurses and outpatient clinics.

How can the practice of nursing be improved? I have asked many people this question — staff nurses, head nurses, supervisors, private nurses, consultants, secretaries and the laity. Their answers are varied.

Nursing care is good now.

It would be nice if a patient's light could be answered faster.

The family is worthy of some consideration.

Surely my friend with a broken hip could be wakened later than 5:45 a.m.

Nurses seem cold and disinterested. They don't really care how you feel.



MARGARET D. MCLEAN

The public health nurse helps me but talks too much.

We need more personnel.

I have too many interruptions.

I have too much to do, to do it well.

One head nurse said:

The leaders are trying to build nursing up to too high a level. Nurses are getting too much preparation now — too much theory and not enough practice. The head nurse's main job is to see that the patient's physical needs are met; that the doctors' orders are carried out; that reports get on the charts.

A private nurse said:

We need more education at all levels — basic, post-basic, university, staff, continuing, etc.

A general duty nurse said:

Let me nurse the patient; take away all my administrative activities.

Each of these remarks is thought-provoking.

I wish I could state that all the nursing care given to patients in hospital and through other health agencies is excellent. For some, I am sure it is; for others it will be adequate; for still others, it is less than optimum, even less than adequate.

Professionally, we are concerned about people and about the care they receive. Perhaps some of us are like the farmer who refused to attend a lecture by a representative of the Department of Agriculture on "Improved Methods of Farming." His reason: "Because I don't farm now as good as I know how!"

Do we nurse as "good" as we know how? What prevents nurses from nursing as well as they know how? What prevents directors, supervisors and head nurses from doing their work as "good" as they know how? We must have a commitment to action — to nurse as well as we know how; to improve the practice of nursing by applying proven solutions to problems; to find better ways of nursing people and to put these better ways into action.

How do we proceed with methods improvement? First, we must be open-minded. We must believe that any job can be improved; that there are many ways to do a job but there is one *best* way. The steps in method improvement are:

1. Select the job to be improved.
2. Assemble all the facts.
3. Question each fact, each detail of the job: What? Why? Where? When? How?
4. List possible new methods and select the best.
5. Develop a plan of action. Put the new method to work.

The job to be improved is nursing practice. Many workers have assembled facts. They have questioned details. They have recommended new methods. We, in our own situations, must put some of these solutions to work.

Some of us have made great strides in improving nursing practice. Some have not. What can we do to further improve practice?

Many solutions have been proven; some are still only ideas. I have gathered these solutions and ideas from many sources: from teachers of nursing; from senior nurses and administrators who represent many hospitals and public health agencies; from student nurses; and from my own experience. There are several avenues through which the improvement of nursing practice can be achieved.

Nursing Service Organization

I have placed nursing service organization first because it is within that framework that the largest percentage of practice occurs.

Is nursing service so organized that nursing personnel can achieve the objective of the service: to give safe, effective care to patients, economically in terms of energy, time, materials and dollars? Does the organization allow the director, supervisor, head nurse and staff nurse to direct, supervise, administer and give such care? Is the major portion of their time spent on the activities indicated by their job description? Or are they so bogged down with looking after *things* that they have too little time to look after *people?*

One nurse said to me: "But you would be helping only in hospitals where the standard of nursing care is poor." This is not so. I have worked with many nursing service departments. They have varied from an 11-bed to a 1,400-bed teaching hospital; from hospitals where nursing care is less than adequate to one where the quality of nursing care is as good as I

have seen. All had one characteristic in common: a sincere desire to improve the practice of nursing.

In some of the functional nursing activity studies that I have directed, the personnel were spending their time in the following manner:

Supervisors: 18.5% of their total time on supervisory activities; 0.9% on housekeeping activities; 5.5% on supply activities; .3% on dietary activities; 12% on clinical activities.

The *head nurse:* 49% of her total time at her own level; 4.4% on clerical activities; 1.4% on housekeeping activities; 2.4% on dietary activities; 4.7% on supply activities.

The *staff nurse:* 76% of her total time at her own level; 4.7% on clerical activities; 3.4% on housekeeping activities; 3% on dietary activities; .4% on laundry activities.

Optimum utilization? Hardly. Why have we let this situation persist?

A methods engineering principle is that a job should be assigned to the lowest skilled worker who can do it well. Recently, I observed an assistant director of nursing checking and signing requisitions from the nursing units to central stores. How could she know if supplies were needed? Why was a requisition necessary anyway? In one 100-bed hospital, with a school of nursing, the housekeeping, dietary, supply, laundry and clerical activities were sufficient to occupy the full time of 14.5 employees but over half of these activities were being carried out by registered nurses! When an administration permits the time that should be devoted to nursing activities to be so decreased by non-nursing duties, how can we ensure the improvement of nursing practice? Extreme examples, you say? Do *you* know how the time of *your* nursing personnel is being spent? Do *you* have facts to present to reallocate non-nursing activities to the proper departments? If not, get them!

To solve this problem I would *not* create a new job using a floor or unit manager. Temporarily, the unit manager might be the best answer. However, these non-nursing activities could be carried out by the appropriate departments and an intelligent, capable ward secretary.

Industries are very concerned about the quality of the products they produce. They must meet predetermined standards. They ensure this by employing a highly skilled person called the quality control engineer. If we are really concerned about improvement of practice, let us employ a quality control engineer in nursing service to ensure the quality of nursing care. This could be handled in one of several ways. If a nursing supervisor were relieved of administrative responsibility as well as non-nursing activities, she could concentrate on the quality and improvement of nursing care. She should be responsible to the director of nursing service. An alternative would be to employ an expert clinical nurse in a consultant capacity. She would assist nurses, as necessary, in the assessment of patient needs; in the development of a plan of nursing care; in the implementation of such a plan. In large hospitals, several experts would be needed; in smaller hospitals one would suffice. Such a consultant might be called an assistant director of nursing. In addition, it is valuable to have a *liaison* nurse, a clinical expert who is a member of the patient care team. Her primary responsibility would be to ensure the quality of nursing care and to provide for continuity of care within the hospital and later with outside agencies.

Another means of developing quality care is a *nursing care committee*. Such a committee would increase the chances of continually improving nursing care. I see its members as expert clinical nurses with the nurse in charge of research in clinical nursing practice as its chairman. Such a committee would soon demonstrate its value.

This organization should make it possible for a registered nurse who likes to care for patients, and who does it well, to care for them and to be recognized in title and pay increments. We must encourage some of our professional nurses who are experts in clinical nursing to continue giving quality care to patients if we are to achieve the provision of first class nursing practice. The presence of the clinical nursing specialist at the side of the patient — whether he is in a hospital bed, attending a diabetic clinic or talking to the public health nurse in his

home — is essential if we are to improve the professional quality of nursing practice.

Dr. Muriel Uprichard, speaking at the RNAO annual meeting said:

> The staff nurse appears to feel that she should be paid more, given more consideration for previous experience if she moves from one hospital to another and more for additional preparation. I agree with all this — up to a point. However, I think the real problem is not at this level. It is at the top levels of nursing.

I agree with her. Dr. Uprichard then discussed the shortage of qualified persons at the top. We must set up the qualifications for the top positions in nursing, provide more educational programs for more nurses to obtain the necessary qualifications and, in a reasonable time, see that they meet requirements.

The director, her associates and her assistants in a nursing service department must be extremely well prepared and competent. They must know a great deal about nursing practice as well as administration if they are to give leadership to their personnel. The latter is one of their most important functions. The director of nursing service must be concerned about the care that patients receive. Administration must care enough to set up a realistic philosophy, choose objectives of nursing service, and then make it possible for personnel to implement the philosophy in their daily activities.

Improved Organization and Administration

If nursing personnel is to be put to optimum use the organization must have certain characteristics. Each department must carry full responsibility for the activities that rightfully belong to it. This applies especially to those departments that should support nursing service: laundry; pharmacy; admitting; housekeeping; central supply; central stores; dietary. Supplies should be provided at the time needed, at the place needed and in the most usable form. One way of doing this is through a completely centralized supply and dispatch system. This is effective in hospitals; it will also work in public health agencies.

The administration must provide for good communication between all departments. The director of nursing should be a member of the top management team. In a few hospitals the director of nursing is an assistant administrator, in charge of nursing.

Hospitals have a responsibility to provide as functional a design of the physical plant as possible. This affects nursing practice. If a new facility — hospital, health centre, or public health unit — is being built, a functional program should be prepared before the architect starts to draw. Nurses should participate in its development.

Education

The practice of nursing can be improved through education at *all* levels — basic, post-basic, university, staff and continuing. Much effort, time and money have been spent on improvement of nursing educational programs. This is good. May it continue! We have experimented with various patterns. We have learned certain things about how to improve the preparation of the nurse practitioner. Why has there not been more change in the three-year hospital school diploma program? Even in our present set-up, where the majority of schools are in hospitals, much more could be done. The hospital school has not begun to reach its full potential. We are all aware of many things that would improve the basic educational program. Why do we not carry them out?

The implementation of some of the recommendations made by Dr. Naegele could be started immediately. The professional nurse must know and be able to give comprehensive care to patients, based on a real understanding of the physical and social sciences. She must be able to assess patients' needs, draw up a plan of nursing care coordinated with the other care received, give that care and/or supervise others in giving it. She must also be able to participate in the development of a total care program in cooperation with the other team members. These are functions of the professional nurse wherever she is practising nursing. We must increase our efforts in our basic programs to prepare the student to be-

come a practitioner at this level.

Nurses must be helped to become skilled practitioners through postbasic and postgraduate educational programs in universities at all levels. Government bursaries, the Canadian Nurses' Foundation and other foundation fellowships provide financial assistance to nurses who are preparing themselves for leadership positions in nursing education and nursing service programs. More of these skilled nurses should be prepared.

Staff educational programs for all levels of nursing personnel are very essential. They must be dynamic. An ongoing program that grows out of the orientation program and meets the learning needs of personnel will help to improve their practice.

Continuing educational programs should be increased. We have the Nursing Unit Administration Extension course for head nurses. Some of the provincial associations and at least one university school of nursing are conducting continuing programs. This is wonderful, but we need more. We need continuing education at a local level where possible. No service agency can meet all of the needs for continuing education of their personnel. Districts and chapters should share in this by sponsoring workshops, conferences and institutes.

In the education of professional nurses there must be increased emphasis on the science of communication if we are to give comprehensive nursing care. Why does a staff nurse say "I cannot talk to Mr. X. He's making too much fuss and is too demanding"? Why need a teacher of emotionally disturbed children say that one of his big problems is that the public health nurse cannot give him any help? This is not really the fault of the nurses. They should have been prepared for all aspects of nursing practice through the basic educational program, a clinical nursing course, university program or staff and continuing educational programs.

Consultation in nursing service and/or education is another method. This may be through conference with another agency or a competent nurse to learn how things are done or problems solved satisfactorily elsewhere. Take advantage of consultant services available from national and provincial nursing organizations or from federal and provincial governments.

Aspects of Quality Nursing Care

A fourth avenue leading to improved nursing practice is to place emphasis on those aspects of nursing care that we believe make for quality. There are several such aspects. First, we must emphasize that nursing is a *personalized service*. The nurse cares for people. In her education and practice she must be with the people for whom she cares. If a person wishes to swim, she must go where the water is. If one wishes to nurse one must be where nursing can occur — with the patient. Patients want personal care from the nurse; they want to know that the nurse understands them and cares about them. They want to be supported, physically and emotionally, by the professional nurse.

Emphasis should be placed on *communication*. Dorothy Smith, says in "Myth and Method in Nursing Practice," *(A.J.N.* Feb., 1964):

> It may well be that the science of communication is more pertinent to nursing than the science of disease or pathology.

To improve practice, nurses must know how to communicate with patients, families, among themselves and with other professional workers. Only then can the nurse know enough about the patient to give him personalized and comprehensive care. Patients say that the nurse is too busy to listen. We have observed nurses talking to other professions but it is a monologue, not a dialogue. Listening is an important part of communication and one communicates better by dialogue.

The continuity of patient care is emphasized in educational programs and in a few service situations. We need to place emphasis on it in all health service agencies, within one agency and among agencies. It has been well demonstrated in method and value. Do we all have an interagency reporting system through which we share our knowledge of the patient and his care? Do we all have a good reporting system in our own organization through which we share our knowledge?

We must control the content of nursing practice by the reallocation of non-nursing activities and by saying what we will and will not take on of those activities that have been considered medical practice. Continually increasing the number of medico-technical functions we take over from doctors will not enhance the status of nursing. It will not necessarily improve the service nurses give people. An example of good collaboration was demonstrated in one large teaching hospital:

> An interesting solution was found to the summer loss of registered nurses in the intensive care units. Second year medical students were employed as special technicians. They were given a course in the operation of cardiac pacemakers, stimulators, etc. and *they* looked after the machines while the registered nurses looked after the patients.

Let us at least stand up and say *what nursing is not.* It is not medical practice. It is not housekeeping; it is not dietary; it is not supply; it is not clerical work; it is not laundry; it is not messenger service; it is not pharmacy.

We must emphasize the importance of professional nursing care for the patient *after* the critical stage of illness is past. Patients have said:

> I received the best care while I was very ill but afterwards I seldom saw a registered nurse.

We know that patients need some professional care after the acute stage is over. Let us be sure they get it.

We should emphasize the role of the professional nurse in the coordination of services to the patient and in the evolution of the total therapeutic plan. She must take her place as a full member in the patient care team.

Needs of the Nurse Practitioner

Nurses are people and have needs the same as others. Administration must make it possible for the nurse practitioner to meet her own needs for social approval, for a sense of achievement, a sense of the importance of the job she does; security — physical, emotional and economic; and for support in anxiety-producing situations if she is to improve her nursing practice. If administration expects her to nurse patients as individuals whom she cares about, then administration must care about the nurse practitioner and show it.

Research

As a final step in the improvement of nursing practice I shall mention research.

Research is defined as:

> a planned, systematic attempt to answer a question or solve a problem.

We need nurses trained in research but not all of us require this training. It is of great importance to have nurses who, by creative thinking, can produce ideas concerning *what we should study*. The area of first priority is nursing practice. I only know of two situations, one in a university school of nursing and one in the nursing service department of a large teaching hospital, where permanent units for research in clinical nursing practice are being contemplated. These facts speak for themselves.

I have dealt with six avenues through which I believe the improvement of nursing practice will come:

1. Improved nursing service organization;
2. Improved agency organization and administration;
3. Improved educational programs;
4. Emphasis on those aspects of nursing practice that we believe provide quality nursing care;
5. Better care of the nurse practitioner;
6. More research, especially in nursing practice.

No one of these avenues will suffice. We must attack the improvement of nursing practice through all six avenues simultaneously. Let us look for better ways but let us remember that there is no use trying to get further knowledge if we are not using fully what we have now. Let us be sure we are directing, supervising, teaching and practising nursing *as well as we know how*. Only then will we be able to make the improvement of nursing practice an integral part of our professional program.

MARGARET D. MCLEAN, M.A.
Consultant, Hospital Nursing Service, Health Insurance, Dept. National Health and Welfare, Ottawa.

Abdominoperineal Resection

ROBERT DYSART, M.D., C.M., F.R.C.P.(C), F.R.C.S.(C)

Abdominoperineal resection of the rectum with permanent colostomy remains the most satisfactory operation for rectal cancer.

In 1908, Miles of London described a combined abdominal and perineal method for excision of the rectum as a curative procedure for rectal cancer. This operation is still the method of choice to-day. Occasionally, it is used in the treatment of non-malignant disease where excision of the rectum is required.

In essence, the operation consists of removal of the rectum and anus and bringing out the proximal bowel to open onto the abdominal wall as the new anus or colostomy. For many years, it was employed routinely in the treatment of any cancer in this area. As experience accumulated, however, it was found equally satisfactory, in certain circumstances, to remove the cancerous segment and reunite the bowel ends by anastomosis, thus avoiding a permanent colostomy. This operation is referred to as an anterior resection of the colon. Which of these two operations, or variations of them, is to be performed in a given circumstance is fairly well established and is dictated largely by the level at which the growth occurs. In low-lying lesions located near the anus, an abdominoperineal resection is definitely indicated because it offers a better chance of a cure and, also, because an anastomosis at this level is technically difficult and dangerous. In high-lying lesions, an anterior resection is performed. Between these extremes, sound judgment is required in choosing the correct procedure.

Diagnosis

The sigmoid colon and rectum are common sites of cancer and, together, account for about 70 per cent of the total number of malignancies of the large bowel (*Fig.* 1). Diagnosis can readily be made by the examining finger or sigmoidoscope in a high percentage of cancers of the bowel. The signs and symptoms of cancer in this area vary somewhat with the level of

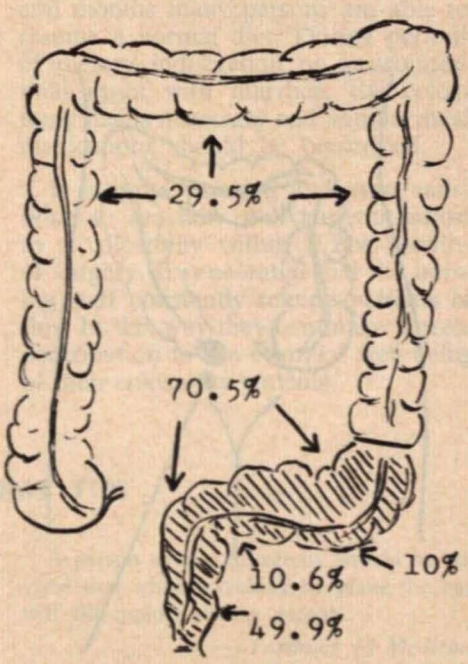


Fig. 1. Distribution of Carcinoma (From Jackman, R. J., and Mayo, C.W. *Surg., Gynec. and Obst.* 93:328.)

the tumor, its size etc., but of particular importance are rectal bleeding and a change in bowel habits. The latter may include increasing constipation, crampy abdominal pain, and abdominal distention. A diagnosis of cancer of the rectum should be confirmed by biopsy in all cases.

Preoperative Preparation

The patient is admitted to hospital at least five days before surgery to

Dr. Dysart is a surgeon in Moncton, New Brunswick.

assess and treat any deficiencies in his general health and, more specifically, to prepare the bowel for surgery. A careful evaluation of his cardiovascular, respiratory and genitourinary systems is essential. Any abnormality is corrected as far as possible. Blood transfusions are given for anemia. Smoking is prohibited since abstinence even during these few days will help cut down on postoperative respiratory complications. The male patient is examined for prostatic obstruction since this is the cause of much postoperative difficulty. The bowel itself is prepared through use of a low residue diet, daily enemas and bowel sterilization carried out with sulfasuccidine and neomycin.

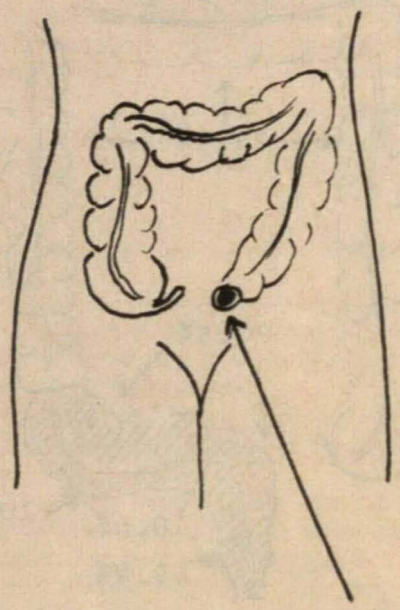


Fig. 2 Permanent Colostomy

Operation

This is carried out in one stage and consists of abdominal and perineal phases. The abdomen is opened through a longitudinal incision and an exploratory examination is carried out to determine the extent of the local tumor and the presence or absence of local and/or distant metastases. A decision to proceed with the operation depends on the findings; but even in the presence of distant metastases, it is often best to remove the tumor, since eventual death is easier from liver failure than from a local spreading tumor.

In removing the bowel, the peritoneum is divided on either side, and anteriorly, and the bowel is freed from its attachments to as low a level as possible in the pelvis. The blood vessels to the area are divided and the bowel itself is divided between clamps at the appropriate level. In these maneuvers, care must be taken to avoid injury to the ureters, bladder, and prostate and, in the female, to the uterus and vagina. The severed bowel is then "stuffed" into the hollow of the pelvis for its eventual removal from below. The upper end is brought onto the abdominal wall as the colostomy (*Fig.* 2). This may be fashioned in a number of ways, but more and more one finds them constructed with the stoma level with the skin surface, and the mucosa of the bowel sutured directly to the skin. The peritoneal floor of the pelvis is re-established and the abdomen closed.

For the perineal phase of the operation, the patient is placed in stirrups or on his side and a wide circular incision is made about the anus. The incision is deepened to the level where the buried bowel is located and this segment of bowel is delivered below. The remaining attachments are divided and the entire specimen removed. After the bleeding has been controlled, drains are inserted and the wound is closed with heavy sutures.

Postoperative Care

The large amounts of blood that may be lost both during and following the operation must be replaced. If a clamp is on the colostomy, it is removed in 24-48 hours; neither liquids nor food are allowed until bowel sounds have returned. The Foley catheter is removed in five to six days and following this a careful check is made of the patient's ability to void. The Lahey Clinic has recently reported that about 25 per cent of its patients have required transurethral resection of the prostate following abdominoperineal resection.

Antibiotics are used routinely by many surgeons and, personally, I prefer a combination of penicillin and

streptomycin. Barring complications, the patient is allowed home 14-20 days after surgery.

Before leaving hospital, he must be fully familiar with and have full confidence in his ability to care for his colostomy. Thus, it is mandatory that adequate instructions be given to him by both surgeon and nursing staff.

A relatively small percentage of patients are fortunate in that the colostomy will develop a rythmicity of its own and empty itself regularly, once a day, usually after the main meal. Most people have to use a colostomy bag, or undergo the mild inconvenience of colonic irrigations at two-day intervals. I believe that the majority of Canadian surgeons favor the former method as they object to bowel irritation which may follow colonic irrigations. However, I have found irrigations most satisfactory.

In this method, instructions are begun six to seven days postoperatively. A Cathcart or Binkley irrigating dome is fitted loosely over the stoma and a well-lubricated 20-22 Foley catheter is inserted into the stoma through the opening in the dome. A quart of water is run slowly into the colon and the return of feces and irrigating fluid runs into the toilet through a plastic conduit attached to the dome. In the beginning, the colon may empty itself slowly, but within three to four months, the entire procedure will take only about 20-30 minutes, following which, the patient is free from soiling for the next 48 hours. During this time, only a gauze pad is worn over the stoma with an elastic binder or girdle to hold it in place.

If irrigations are not to be used, a colostomy bag is usually worn. There are many equally satisfactory types available and all make use of disposable plastic bags that fit snugly over a plastic dome which is placed about the colostomy. A constipating diet is essential in all patients, but after several months many persons are able to resume a normal diet. During periods of dietary indiscretion or gastrointestinal upset with diarrhea, the colostomy bag is necessary and antidiarrheal medications should be prescribed.

It is quite amazing and most satisfying to see how well patients adjust to a colostomy within a few months of surgery. It is essential that the nursing staff constantly remind patients of this. In this way they can make a great contribution to the eventual well being of their colostomy patients.

COLOSTOMY TIPS

Women who have colostomies or ileostomies will need to wear clothes that have a slight fullness *if they use a bag or dome.* If they use only a dressing, girdle or some type of abdominal band over their 'ostomy, gores or flares in skirts will not be necessary.

— *A Colostomy?*

* * *

There are a few symptoms that indicate an in-between check-up with the doctor for patients with colostomies:

1. Repeated nausea and vomiting;
2. loss of appetite;
3. excessive gas;
4. severe cramping pain in the abdomen;
5. unusual diarrhea or constipation;
6. bleeding from the colostomy opening.

— *A Colostomy?*

A person with a colostomy should be advised that when travelling by plane the bag will fill rapidly during ascent.

— *Textbook of Medicine*

OLD DRUG: NEW USE

A drug being used in gout research may prove to be effective in preventing a form of heart disease, a University of Toronto researcher believes. The drug, known as Anturan, has been found to affect the blood particles which collect around cuts in blood vessels and bring on clotting. Research has indicated that Anturan, besides reducing the uric acid level in the blood of gout sufferers, seems to curb release of an inflammatory substance which causes hardening of the arteries.

A Small Price to Pay

AILEEN E. BARER

The patient with a new 'ostomy requires support that can best be given by the person who already has one.

Introduction

Any patient undergoing surgery suffers a shock to his system. In the normal course of recuperation, he recovers, feels better, and resumes his normal life.

But what of the patient whose surgery leaves him with a colostomy or ileostomy? I am a nurse, a wife, a mother of five, a club leader, active socially — and I have a colostomy. In 1962, I underwent such surgery, made necessary by ulcerative colitis which I had suffered from since 1957. My recovery and rehabilitation were quick, painless, and complete. But being a nurse, I had read extensively about the disease throughout the five years of my illness and was prepared — and really thankful — to have the colostomy. What of those patients who lack medical training, and who have no warning? The doctor is sympathetic and understanding, but he is a busy man. The general duty nurse and the head nurse are also sympathetic and concerned, but they too are busy, and often their knowledge of the practical, everyday aspects of living with an 'ostomy are limited. Only someone who lives, works, plays, and leads a normal life with an 'ostomy can really convince an apprehensive patient. No matter how successful the surgery, the patient's ultimate recuperation depends upon his acceptance of the 'ostomy and, in turn, his family's acceptance of him.

Preoperatively

'Ostomies are most often performed for ulcerative colitis and for cancer of the rectum. The patient with ulcerative colitis is usually young, and often has been ill and incapacitated for some time; he is apprehensive, exhausted, frustrated, and frightened. His emotional instability and apprehension is frequently trying to the patience of the doctors and nurses. The initial inclination to avoid such unpleasant people *must* be repressed or the patient needing the most attention will get the least. It is here that an experienced person becomes invaluable. The patient with cancer of the colon or rectum may still be in good health, having suffered no pain or restriction on his life; yet now he is expected to accept the fact that he must live the rest of his life with an 'ostomy.

It is easy to see that psychological preparation of these patients is a must. If possible this preparation should be done by someone who has an 'ostomy and who has adjusted to it.

Postoperatively

Following surgery, it is essential to constantly reassure the patient. Remember that he watches your every word and facial expression for reassurance that he is not repulsive, and that changing his dressing is not a disgusting chore to you. Never pass up an opportunity to educate as you work. Do not push your patient into looking, or "doing" too soon; encourage his assistance as he shows more willingness to learn to care for it himself. Reassure him that the 'ostomy will get much smaller as time goes on, that he will be able to dress much the same and, that *it is a small price to pay* for good health. Take time to answer his questions honestly; encourage the surgeon to take time to explain even trivial matters. It really is important to this patient.

Some doctors believe in irrigation

Mrs. (Gordon) Barer is a graduate of St. Joseph's Hospital School of Nursing, London, Ont. She resides in Victoria, B.C.

of the colostomy. Here, again, it is important that someone experienced teach the patient to irrigate *before* he leaves the hospital. It should be explained that an irrigation is really an enema to clean out the remaining bowel, and to prevent unexpected movements; that excellent equipment is available to make the chore less difficult. Irrigation involves gently dilating the colostomy opening with a lubricated, rubber-gloved finger, then gently inserting a catheter which is attached to a rubber enema bag. After having expelled the air from the tubing, the catheter is inserted gently with the water flowing slowly. Experience will dictate how much water is needed to completely cleanse the bowel. A cup which fits over the colostomy and has rubber tubing which runs between the legs into the toilet is a most effective way of disposing of the discharge. Allow 40-60 minutes for irrigation. This time can be spent reading, listening to the radio, and relaxing. Emotions do affect the bowel, and it is wise to allow an unhurried hour for irrigation.

The person teaching this procedure should be patient, knowledgeable, and sympathetic. Practice *will* make perfect, and soon the patient will be delighted to find that a properly performed irrigation will free him from bulky dressings and odor and lead to the next step, which is a properly fitted appliance — either a temporary plastic bag, or a permanent-type rubber bag. In a well-controlled colostomy, a piece of gauze covered by a square of plastic, held on by a girdle or belt is often all that is required. The variety of appliances on the market is large and, again, an experienced person can be of much help in choosing necessary equipment. Where the patient has had an ileostomy, he will be fitted with a temporary appliance immediately after surgery. He should understand that he will have no control over the discharge, but that a custom-made appliance will make it possible for him to do everything and go everywhere.

Patients should be taught that the discharge from the stoma is very irritating to skin, and that scrupulous cleanliness is a must. Skin care must be kept simple; Gentle cleaning with a mild superfatted soap, followed by generous flushing with warm water is most effective. Do not rub the skin; pat with cotton, and expose the skin to air whenever possible. When mild irritation occurs, Karaya Gum is an excellent healing agent and will not interfere with the appliance adherent. Appliance cements are themselves very soothing. It is essential, of course, that the appliance fits properly.

The patient should understand that:

Emotions have a definite affect on the bowel. If upset and the irrigation does not work satisfactorily one day, there is no cause for alarm.

'Mycin drugs cause diarrhea, and codeine constipates. A patient with an 'ostomy should not prescribe medications for himself.

A small amount of bleeding around the stoma is normal, but bleeding from within is not.

There are no nerve endings in the bowel, and, therefore, it has no "feeling."

Since there is no sphincter muscle, control can only come from irrigation, diet, exercise and good health habits.

After an abdominoperineal resection or total colectomy, the perineal fissure may drain for a long time.

Patients with colostomies can obtain life insurance if they desire it.

Chances are that no special diet will be necessary — subject to the approval of the doctor. An 'ostomy patient soon learns that beans, peas, corn, cabbage, and cucumber, for example, will cause excess gas and must be eaten in moderation. The amount of fruit and raw vegetables to consume will depend, in many cases, on whether these foods caused loose stools prior to illness. This also applies to "roughage foods," such as bran, oat meal, and whole-wheat products. It is most important to *chew food well* and to eat well-balanced meals; to be free from tension at meal-time and to maintain usual weight, avoiding obesity. These facts need to be given to patients by an 'ostomy patient.

Anyone reading this article cannot help but realize that I advocate using an experienced 'ostomist to rehabilitate these patients and to lecture to students, graduate nurses, and interns. Several large hospitals employ "stomal

therapists" whose sole job is to rehabilitate and teach. In small hospitals, where this is financially impossible, there should be someone "on call." Many cities have colostomy-ileostomy clubs whose members are eager to help. The objective should be to dispel fear and apprehension with knowledge and understanding and to replace generalities with specific "whys" and "hows."

Conclusion

One of the main functions of the stomal therapist or trained nurse is to teach acceptance. The patient often feels helpless after this surgery and becomes easily depressed. Emotional defences are down; anger and hostility combine with anxiety and a feeling of spiritual loss. The patient must be counselled in his relation to his family. Counselling the family before the patient leaves the hospital is excellent insurance against a setback after discharge. Psychiatric help may be necessary but if the patient can be helped by a person with an 'ostomy, so much the better.

An 'ostomy is a big price to pay for relief from the symptoms of ulcerative colitis or cancer of the rectum—but it buys freedom from intractable invalidism and chronic debilitative illness. For many patients, who have been kept from normal living by ulcerative colitis, 'ostomy has provided the opportunity for marriage and childbirth; a gainful occupation and relief from dependence on physicians and hospitals. An 'ostomy is a handicap but the limitations imposed are infinitely less than those imposed by the disease itself.

Dr. Tom Dooley, in his book *Edge of Tomorrow* states:

One of Dr. Schweitzer's most important concepts is the *fellowship of those who bear the mark of pain.* Who are it's members? Dr. Schweitzer believes the members are those who have learned by experience what physical pain and bodily anguish mean. These people all over the world are united by a bond. He who has been delivered from pain must not think he is now free, at liberty to continue his life and forget his illness. He is a man whose eyes are opened. He now has a *duty* to help others in their battles with pain and anguish. He must help to bring to others the deliverance which he himself knows.

This has been my aim.

The author wishes to ackowledge her indebtedness to the *Colostomy Ileostomy Rehabiliation Association Journal,* P.O. Box 121, Phila. 5, Pa., as a source of information and encouragement.

In the Good Old Days

(*The Canadian Nurse* — OCTOBER 1924)

The first "Congress of French-speaking Nurses" was held at the University of Montreal on September 8 and 9. Several hundred nurses and nursing sisters from Canada and the U.S.A. attended.

The president, Sister Fafard of Notre Dame Hospital, stated that the aims of the organization were: 1. to hold an annual congress during which discussions should be held on various phases of nursing; 2. to prepare the program for the summer postgraduate courses, and 3. to publish a monthly magazine, called *La Veilleuse* which would set forth all the activities of nurses in every part of the world.

* * *

Comments by Miss Jean I. Gunn, Superintendent of Nurses, Toronto General Hospital, concerning student government:

* The superintendent of nursing must be prepared to see many of her strictest rules and regulations discarded, and an entirely new order of things introduced.

* Since the system of self-government is limited to the residence life of the student, and does not affect the discipline of the hospital, it is wiser to allow them to try out their own suggestions rather than condemn them without a trial.

* The necessity of allowing the student group to assume all responsibility and to accept their council's ruling cannot be overemphasized.

IN A CAPSULE

REGIONAL ENTERITIS

In reviewing case histories of 98 patients with regional enteritis, it was found that more than half had their onset between the ages of 11 and 30 years. Men were more commonly affected than women.

The onset in 44 patients was acute and closely mimicked acute appendicitis. Twenty-eight patients had had abdominal surgery prior to the onset of symptoms. Major symptoms were abdominal pain, diarrhea and weight loss. Abdominal tenderness, fever and abdominal mass were the most consistent physical signs. The most valuable diagnostic procedure was radiological examination of the bowel.

The primary treatment of regional enteritis remains medical. Surgical intervention is necessary only for the complications of intractability, obstruction, fistula, abscess formation, anal and rectal complications, massive hemorrhage and perforation.

A perfect operation for this disease does not exist. Although the recurrence rate following surgery averages approximately 30 per cent, the disease is well controlled in the majority of patients with medical and /or surgical treatment. — *C.M.A.J.*, July 4, 1964.

SNAKE BITES

The only venomous snake in Canada is the rattlesnake and this reptile is thinly distributed in limited areas in the southern fringe of the country. Its venom is exceedingly toxic. A field mouse, struck by a Massasauga rattlesnake, dies in about two seconds.

It is striking evidence of the deadly toxicity of rattlesnake venom that the quantity intended to kill a field mouse is quite capable of killing a human being if a full dose of venom is delivered through the skin into the subcutaneous tissue. Nevertheless, the risk of rattlesnake bites to human beings is minimal.

Much can be done to avoid rattlesnake bites by a few simple precautions. While in the bush, one should wear clothing heavy enough to prevent penetration of a rattler's fangs through the underlying skin. When berry picking or preparing a camp site, bushes should be stirred with a stick before sitting down on the rocks.

The mainstay of treatment of rattlesnake bite is the Polyvalent Antivenin, Wyeth. It must be used with caution since, like all antisera, it is harmful to those who are sensitive to horse serum. Sensitivity testing is essential.

The application of a narrow tourniquet (e.g. a shoe string) is also helpful. It should be tied sufficiently tight to compress the skin against the underlying fascia without interfering with arterial circulation. This occludes the lymphatics and delays absorption of the venom. The affected limb and the patient should be kept quiet. — *C.M.A.J.*, 90:1472, June 27, 1964.

THE ILLEGIBLE SCRAWL

The story is told of the physician whose illegible scrawl on a prescription blank made it possible for his patient to use the Rx as a railroad pass and to wangle a free seat at Yankee Stadium during a World Series. This story, like others, is based on the fact that many physicians are atrocious penmen. Though the situation lends itself to humor, in reality it is anything but funny.

A recent study at one hospital revealed that 178 medication errors had occurred in a seven-month period and were attributable, in part, to illegible handwriting. Nurses, the study indicated, were at fault in only a few of these instances. It would appear that the need for speed, the distastefulness of such "clerical details" and a failure to realize the seriousness of misread orders all contribute to the house staffers' scrawl. — Arkin, Joseph. Reading and Writing. *Canadian Doctor*, June, 1964.

To Profess Is to Serve

W. L. MORTON, B.LITT., M.A., LL.D.

Any profession is a grave matter, whether it deals with fact or fiction, truth or falsehood, life or death; one must, therefore, treat it lightly, or be overwhelmed.

One who professes competence, one who professes to serve, must not take himself or his profession too seriously, at least publicly. The dear old lady who said, "I am a Baptist, I have been a Baptist all my life, and nobody is going to make me a Christian," was a trifle too zealous in her profession of sectarian faith. A professional must be, like John Bunyan's lady, "an ornament to her profession," but not a publicity release for it. As we know a profession is not a conspiracy against the laity — peace to Shaw — so we also know it is not a claim to omnipotence.

Professions are human occupations working within human limitations. What gives a profession quality is the character developed in the people who follow it. That character comes from the personal devotion, or the *personal commitment*, of people to their calling. You will, I am sure, excuse the obvious reference to what transformed hospital charwomen into nurses, over a century ago, and created the profession of nursing. It was the commitment, the extraordinary personal dedication, of that great Victorian gentlewoman, that pitiless organizer who worked others to death and herself ill, Florence Nightingale. She was, you will recall, one of the most formidable personalities of a century of strong personalities, and in strength of purpose ranks with Bismarck and Lincoln, Wilberforce and Pasteur.

The personal commitment to a calling, therefore, is the root of a profession in man or woman. Unless there is, or develops, such a sense of vocation, of being called, the spirit of profession is lacking. Out of that vocation comes two things: One is competence; the other is service. The professional man is capable of giving the service he professes. He will give that service without reward. It follows that he has a responsibility to be competent in his profession and to be ready to serve at any and all demands.

These characteristics of a profession are only too easy to state. The statement exhausts the subject of professional character, to be ready to serve and to be able to do so. But professional life is, in fact, full of complications and perplexities, and never more than today.

How does one achieve competence? The demand for people trained to ever higher standards is increasing rapidly. The cloud-burst quality of the increase in the enrolment of students is, in large part, a demand for more professionally trained people. More training and more people trained, will be needed in all professions from now on. More and more callings, such as that of the social worker, are rising to professional status every year. More training, then, and higher standards of training, will mark both the old and the new professions.

The meeting of professional responsibilities is becoming more difficult all the time. The reasons are two. One is the growth of specialization in a profession, as in a medical clinic, and the organization of sub-professions and technologists around the specialized practitioners. There follows the growth of impersonality in a profession and the possible decline of the old responsibility to patient, or client, or pupil. It has had to be replaced by the growth and cultivation of a group loyalty to the firm, clinic or school. This is a good thing in itself, and it may be an adequate one. However, to anyone

Dr. Morton is Professor of History, University of Manitoba. He gave this address at the 50th Anniversary of the MARN.

trained as a nurse the idea that professional responsibility lies anywhere other than directly to the patient with whom one deals seems a risky departure. We know, but we do not wholly accept, the decline of the individual and independent professional. The erosion of the former position of the family doctor, the family lawyer, the teacher who was a friend as well as an instructor, that erosion we have willed by our own choices, brought about bit by bit. As a whole, however, we have accepted it with reluctance.

A professional man such as the family doctor has been a distinctive element in our social life; and is our representative image of the professional man. Much has characterized him in the popular mind: devotion to his calling, personal integrity, independence of mind and conduct. He remains the professional ideal, but his numbers are decreasing. They are decreasing even more, relative to the numbers of professional and semi-professional people engaged today in professional groups, medical clinics, hospitals, social services, universities. The professional man as an independent practitioner, managing his own life, discharging his own duties, supported by his own fees, is no longer the dominant influence in professional members or professional mores. Professions are ceasing to be individualistic. Like every other walk of life they are becoming, in a sense, collectivist.

In touching on this essential character of the professional man, I have deliberately been idealistic. The practice of the greater professions has long won most professional men comfort and station, and even wealth. The professions have defended privileges as well as standards. Not less have they developed a certain sense of superiority, a professional *esprit de corps*, that has made them not invulnerable to Shaw's quip that they are inevitably "a conspiracy against the laity."

The truth is, of course, that a particular character and role of the professions, as exemplified by medicine, has passed away with the social order in which it flourished. In the liberal and individualistic societies of the last century, in which times the professions reached this height of autonomy and prestige, the concept of a standard of service maintained by a private profession under public license fitted in well with the freedom of private enterprise and the belief that the private pursuit of lawful occupations would result in public welfare and social harmony.

The organization of economic and professional life, however, has greatly changed in our time. The control of business has passed from the owners of property to the managers of corporations. Enterprise has become bureaucratized, as government, of course, already was. The result of these changes are many. Some are well known and very relevant to our theme: the decline of the private and the family firm; the disappearance of the independent craftsman and the independent grocer; the decline of the private practitioner.

People of all kinds, then, work for a corporation within a bureaucratic framework. They do not make decisions; they do not possess autonomy; they are only at best responsible persons in part, for responsibility is diffused throughout the bureaucracy. The only full persons are the decision-makers, the managers.

I cite these changes without comment. They have happened and they are proceeding in the world in which we live, which seems likely to be the only world in which we shall have to live. What concerns professional people is the question of what happens to the *personal responsibility* of the lawyer to the client, the nurse to the patient, the teacher to the pupil, that is, the essential nature of professionalism.

The matter raised by this question is not, I think, one of whether the professional man is a free practitioner or a salaried employee. An individual's integrity, responsibility and freedom are not diminished by his receiving his income as a salary, or as wages. That they were is a prejudice carried over from a vanished social order. A professional is paid, after all, to be himself, and to perform the services he was trained to perform.

The important question is whether the decision as to what medicine to prescribe, what historical truth to stress, or what attitude to assume be-

fore a difficult client, is either to rest with him as a professional, or with the manager as the bureaucratic decision-maker.

Here I think we have the crux of the responsibility of the professional today. Is the professional practitioner, nurse, teacher, doctor, lawyer, engineer — all who claim to be professional in competence and in ethic — to remain responsible for his conduct in the exercise of his profession? Or is he to be a person under orders with the responsibility for his acts resting with the decision-makers, the managers of firms, the directors of education, the presidents of universities?

Such is the crucial question. It is not, of course, an abstraction troubling professors who have been set free to worry about things that worry no one else. It is a very practical question. Most of you must touch it in some form every working day of your lives. It is causing a slow, good-natured, but very fundamental conflict within Canadian universities. Presidents and deans are ceasing, have ceased to be senior scholars with authority in their own right and persons, and have become the managers of bureaucracies, exercising an authority given them by appointment from outside the body of professional scholars. We all know that much of the resistance of the doctors of Saskatchewan was against a too great readiness of the politicians to give power over the medical profession to a bureaucrat careerist.

So complex a matter, one that readily becomes passionate, as in Saskatchewan, shows, all too sadly that it is necessary to be clear and precise. Let us try to put the basic questions more simply, in partial questions. First, is it possible for a professional man to be a salaried man, and remain responsible for the quality and character of the service he performs? I think he can as the careers of professional men in that position demonstrate. To be salaried, then, is not to forfeit the professional character.

One may object, however, that to accept salaried dependence in place of free practice may not lead to loss of professional independence and responsibility in one generation or two, but that it must do so eventually. I do not believe this is true. It may be regrettable to give up greater incomes from fees than those from salaries, but professional independence and integrity need not depend upon free practice and remuneration by fees. I think this because I think the threat to independence comes not from the mode of payment, but from elsewhere.

Can a professional work in an organization, a clinic, a history department, a legal firm without forfeiting his professional integrity? In these work situations he specializes, fits into a system of service, does not make decisions other than those immediate to the task assigned to him in the organization. Is this a diminution of his professional character? Again, I think not. A professional in such a case undertakes a professional assignment, and is left to carry it out as a professional.

At this point one may note that the needs being met by the growth of salaried, specialized and bureaucratized professions are very great and pressing. The teaching profession has had to be organized in this way to meet the demands of mass education. The medical profession is now being organized in the same way to meet the needs of mass medical care.

This is true, but the parallel is an ominous one. The teaching profession, other than in universities, (which part is now also threatened), has suffered greatly at the hands of public control. While its conditions are now improving, the profession is still absurdly and harmfully hampered by the controls imposed by trustees and educational bureaucrats. Teachers ought to make their own curricula within broad limits, and be responsible for the results. Like all professions, teaching must be essentially free if it is to be imaginatively alive and morally responsible. The controls imposed on the teaching profession by society today could, if not resisted with some success, destroy the profession of teaching, just as similar controls could destroy the profession of medicine. Thus, at a time when formal education and medical care may at last be available to all, society may well be preparing to destroy the character and the spirit — the professional character with its spirit of competence and service.

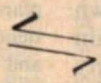
If salary and organization, however, do not of themselves threaten to do this, what does? What is it in our concept of paid and organized professionalism that threatens to destroy the professions? It is, I believe, *a wrong concept of authority*. A free practitioner is controlled only by the demands, many or few, made upon him by his patients, or his pupils. But in an organization, someone must decide who is to be engaged as a professional: someone must create the conditions of work; someone must organize and direct the whole as a whole. From this comes the need for management.

Management, however, has acquired its habits and its ethos in two authoritarian schools, that of the state and that of business. One has the authority of political sovereignty, the other that of legal property. There is no such basis in a profession. Professional authority derives only from competence and service. As John Wycliffe taught, dominion is founded on grace.

It follows that the paid professional working in an organization ought to be assigned to his work, but he ought never to be directed in it. He must also have a voice in the direction of the whole. He should never be under the direct authority of someone who is a layman to the profession. He and his colleagues, directly or by representation, should make the policies and control the managers of their organizations. Hospitals, universities, legal corporations, schools, must be controlled, in some measure at least, by their proper professional people, never by managers alone, or by laymen alone. Only thus can professional integrity and organization be reconciled.

To ensure that the bureaucracies of professionals have such organization is, I think, the chief present-day responsibility of professional people. If we fail to discharge this responsibility, we shall fail to be professionals.

MUSCULAR DYSTROPHY
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plus additional public health articles

IT CAN HAPPEN HERE

W. S. HACON, M.D.

On the alert for local disaster.

The greatest disaster in human history occurred one fine summer day in peace-time. The Tokyo earthquake of September 1, 1923, with its accompanying fire storms, land slides and tidal waves took the lives of 140,000 people and injured a further 104,000. Earthquakes, tornadoes, hurricanes, explosions, fires, train wrecks, air accidents and other disasters are striking our growing communities more and more frequently. The added threat of nuclear weapon attack must surely convince the boards of governors and staffs of Canadian hospitals that they have a definite responsibility to assure themselves that their hospitals are prepared to act in a disaster.[1]

All the disasters of recent years have been closely studied and many lessons have been learned. One of the outstanding lessons is that a hospital cannot effectively prepare itself on its own to meet disaster situations. It must gain the cooperation of many community agencies such as the police, and fire services, the local civil defence organization, the St. John Ambulance Association, the Canadian Red Cross and others. In fact, the primary need is for a community disaster plan. If no such plan exists the hospital can, and should, stimulate the community to create one.

A second significant lesson is that no community is immune to disaster. Along with this lesson goes the observation that disasters occur frequently. Recent disasters include the Alaskan earthquake; the fire at the Hotel Dieu St. Vallier in Chicoutimi, P.Q. when 805 patients had to be evacuated and accommodated elsewhere; the propane gas explosion at the Indianapolis arena (71 killed, 370 injured); the TCA jet aircraft crash at Ste Therese, P.Q. (118 killed); the chlorine gas poisoning in Cornwall, Ont. (100 poisoned); the boiler explosion in a New York telephone company building (21 killed, 100 injured). One could go on recalling disasters of all sizes. These examples should be enough to convince us that *it can happen here* and that we should do something about it.

Another good reason for having our disaster planning in good order is the recent change in accreditation standards. The foreword of the January, 1963 edition of the *Standards* states: "Changes to be noted in this edition include the listing of emergency services as an essential service." Later in the book it is noted that,

> There should be a written hospital disaster plan for the care of mass casualties and this plan should be coordinated with the inpatient and outpatient services of the hospital and with appropriate community services and agencies.

Under the heading "Medical Staff," we read,

> Whether or not an emergency service is organized, there should be adequate medical staff service for emergency care of patients and there should be medical staff participation as appropriate in disaster planning.

The text of the "Application of the Standards to the Smaller and Special Hospitals," notes that

> A written plan for the care of mass casualties is not mandatory for every accredited hospital but a suitable hospital disaster plan to look after internal and external disaster should be developed. The decision as to need for planning for mass casualty care depends on both local and national circumstances. Where formal planning is desirable, it should be done.

Dr. Hacon is Medical Consultant, Medical and Hospital Services, Department of Health and Welfare, Ottawa.

[1] *Hospital Disaster Planning 1964:* Dept. National Health and Welfare.

Finally, the *Accreditation Guide No. 3*, June, 1963 states that

The change of wording, in the standards which concern disaster planning, is intended to indicate that every hospital plan for care of mass casualties must be suitable to the demands which may be made on the hospital concerned. Council will expect to find a formal written disaster plan in all larger teaching hospitals, in all regional hospitals and in larger community general hospitals. Many specialty hospitals should have their disaster planning coordinated with neighboring general hospitals. Very small general hospitals should plan for mass casualty care by a suitable extension of their arrangements for emergency service. These plans should be written.

A third incentive to disaster planning is the arrangement for the issue of hospital disaster supplies from the federal Emergency Health Services stockpile to all hospitals with satisfactory disaster plans. Once a plan is approved by the provincial hospital disaster planning committee, the hospital will be issued with one EHS kit for every 25-50 beds. Each kit contains Dextran, bandages, burn dressings of the larger sizes, shell dressings, intravenous stands, litters, emergency medical tags and a book for recording admissions and discharges.

THE SPECTRUM OF DISASTER

A convenient system of grading disasters for use by hospital planners has been developed. It takes into consideration two major factors: the number of living casualties arriving from the disaster; the size of the hospital. The gradation is called the "spectrum of disaster." It extends from a small internal emergency — a grade one disaster — right up to a disaster of the magnitude of a nuclear attack, a grade seven disaster.

If we prepare ourselves for the more probable local peace-time disasters, represented by the lower grades, we will find ourselves prepared to a large extent for the upper grade but less probable disaster of a nuclear attack. One of the first steps in disaster planning within each hospital must of course be a very close examination of the hazards likely to affect that particular hospital.

Grade 1 — Internal Emergency. This is an emergency within the hospital such as a fire, an explosion or an accident that endangers the safety of patients and staff. Most hospitals are already well prepared for this grade of disaster.

Grade 2 — Minor Emergency. The number of casualties expected to arrive in the hospital can be handled in the emergency department provided that its personnel is augmented by additional staff drawn from those on duty in other areas. The total number of casualties to be admitted is between 5 per cent and 10 per cent of the number of beds set up in the hospital. It should be noted that these percentages refer to the number of patients requiring admission and that, in most disasters, only about one-half of the patients arriving do require it.

Grade 3 — Minor Disaster. The number of casualties expected is large enough to require extension of the reception and treatment areas in the hospital but the admission load can be handled by the hospital without having to discharge more than a few inpatients. The total number of casualties to be admitted is between 10 per cent and 30 per cent of the number of beds set up in the hospital.

Grade 4 — Distant Major Disaster. The hospital is more than 100 miles from a major disaster such as a tornado, a large accidental explosion or a nuclear strike. It is requested to dispatch personnel to assist in the various treatment centres set up within 100 miles of the disaster. The need for hospital disaster planning in this grade will increase as provincial and municipal plans for major disaster are developed by the Provincial Emergency Health Services.

Grade 5 — Nearby Major Disaster. The hospital is *within* 100 miles of a major disaster and is required to admit casualties totalling more than 30 per cent of the number of beds set up. There may be a need under conditions of national disaster for expansion to twice the normal capacity.

Grade 6 — Radioactive Fallout. The hospital is covered with radioactive fallout and must continue to function.

Grade 7 — Target for Attack. The hospital is in a target city and a nuclear attack is imminent.

HOSPITAL DISASTER PLANNING MANUAL

To assist hospitals with their planning, the Emergency Health Services Division of the Department of National

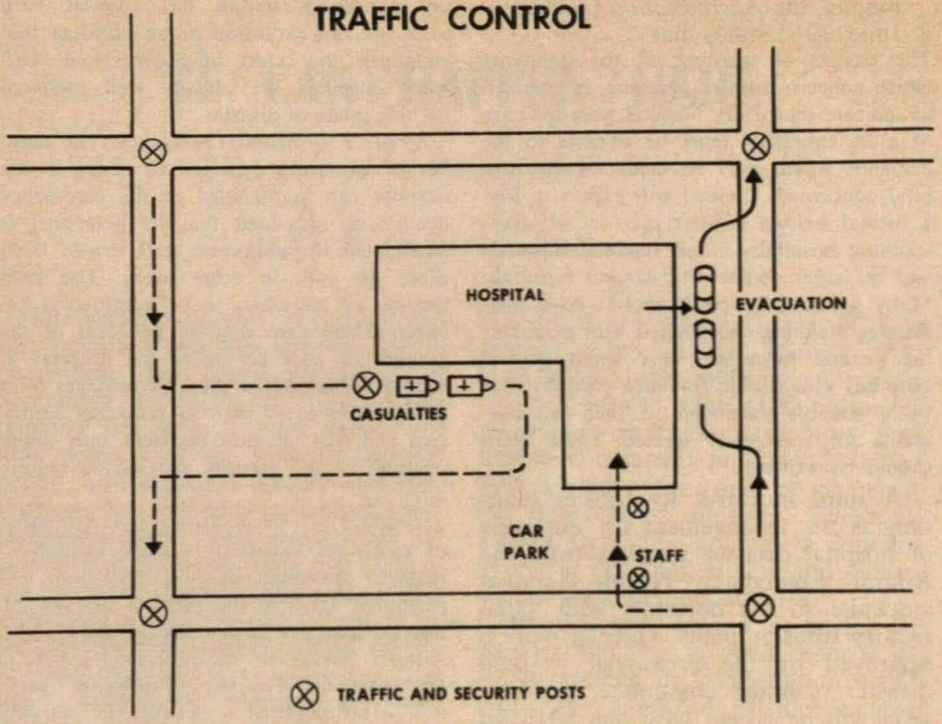


Fig. 1

Health and Welfare has published the manual *Hospital Disaster Planning 1964*. The text of the manual covers the planning responsibilities of senior hospital personnel. It offers advice in how to set about the task of planning. In order to assist the emergency committee with the mechanics of preparing the disaster plan, the back of the manual contains a control sheet for functional areas and a series of 26 check sheets — one for each of the 26 functional areas which may have to be set up or reinforced in order to deal with a sudden large patient workload. The intention is to provide the emergency committee with a ready means of transmitting their planning directives to the persons designated as responsible for each of the functions. Having prepared the over-all plan and having decided which functional areas will be set up, the committee can tear the check sheets out of the book, fill in the blank spaces and hand the sheets to the Area Chiefs for further action. Each check sheet describes the purpose of the functional area and offers a list of planning steps required to get the area into operation.

Other chapters in the manual are concerned with the reception and care of casualties; protection against radioactive fallout; the problem of evacuation from a target city; hospital supplies; the maintenance of a living plan; community disaster planning. There is, as an appendix, a special report form for use by hospitals actually involved in a disaster. This is designed for educational purposes only. Lessons learned from the experiences of a hospital will be passed on to other institutions for their guidance in planning.

A second appendix offers advice on how to set up an exercise in a hospital. Another contains a classification of Canadian hospitals based on radioactive fallout exposure probabilities.

RECEPTION OF CASUALTIES

Our primary concern in disaster planning is the reception and care of casualties from a disaster situation. The arrival of large numbers will create a problem for any hospital. It is convenient to survey this problem by considering how the casualties might flow into and within the hospital and, at the same time, to determine what ser-

vices must be provided for their care.

To avoid confusion at the outset, we must exercise control over the movement of the three groups of people trying to enter the hospital *(Figure* 1). These are the casualties, the staff and the public. The local police should set up traffic control posts on the streets around the hospital; the hospital staff or the police should control the movement of vehicles and persons within the hospital grounds. The public must be prevented from entering the hospital by a system of emergency pass cards for the staff and for recognized volunteers. Enquirers should be redirected to a nearby information centre.

Ambulances and other vehicles bringing casualties to or evacuating patients from the hospital should be directed through the hospital grounds by clear, one-way routes. Casualties should be unloaded from the ambulances quickly and admitted through the designated entrance to a large area where they can be examined and sorted into treatment categories. The flow of casualties from this key point through the treatment area is shown in *Figure 2*. The reception and sorting area should be in a large entrance hall or in a large room nearby, such as a cafeteria. A large space is needed because this is where most of the confusion takes place. The best doctors should be allocated to this area for the purpose of examining all casualties and determining their treatment requirements. Each doctor should be assisted in his examination by a nurse. He should have a reception clerk standing by to receive dictation. These three people comprise a sorting team. The number of sorting teams should be determined on the expectation that one team can process between 25 and 30 casualties per hour. There is no place here for hasty examination or the initiation of treatment.

Provision must be made for treating those with minor injuries who can subsequently be sent home or to some other type of accommodation. The serious cases for admission will require varying types of treatment, some urgent, some less urgent. Facilities should be set up for preoperative resuscitation, anesthesia and emergency surgery, the treatment of burns and shock cases, emergency wards and the treatment of fractures. Casualties may be suffering from such diverse injuries as chlorine gas poisoning, food poisoning, and carbon monoxide poisoning. Some flexibility is required in the treat-

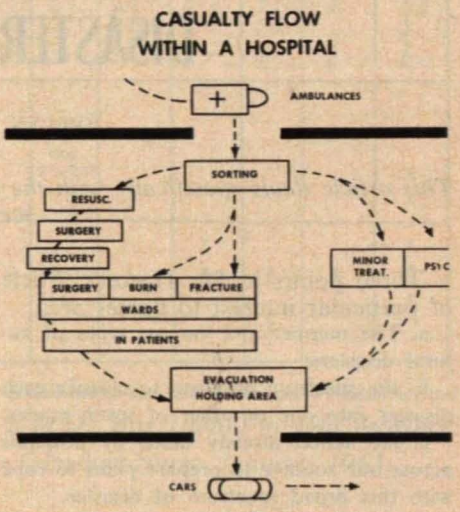


Fig. 2

ment areas. The flow of patients to these areas is a function in itself. Control over this movement should be delegated to a senior member of the hospital administrative staff. The extent of the treatment facilities to be provided must be determined early by the disaster committee because they constitute the core of the disaster plan.

One other function, evacuation of patients, should be specially mentioned because of its importance and because it is not a normal function. Organization is needed to move patients to safety in an internal emergency; to move patients to radiation protected areas; to free hospital beds by discharging patients to their homes; to move designated patients to other institutions. The main purpose is to empty wards rapidly either because the area is dangerous or because they are required for the reception of casualties. There must also be a place for patients to wait in safety for transport and for documentation. A large area well away from the treatment area should be set aside for this purpose.

CONCLUSION

In this brief paper, an attempt has

been made to demonstrate that disaster hazards are very real hazards; that it is our duty and to our advantage to make plans to overcome the problems encountered. The various grades that make up the spectrum of disaster have been described and a method suggested by which we can achieve our aims.

DISASTER NURSING

EVELYN A. PEPPER

This article deals specifically with the responsibilities of the nurse in emergency services.

Three points in Dr. Hacon's article of particular interest to nurses are:

a. The number and various types of natural disasters;

b. the spectrum designed to classify each disaster into one or other of seven grades;

c. the action already taken by hospitals across our country to prepare plans to cope with this broad spectrum of disaster.

It is noteworthy that, of the seven grades of disaster, the first five have already been used to classify natural disasters that have occurred in our time and have been effectively handled. This fact alone should inspire any health worker, who has not already done so, to work toward the ultimate goal of preparedness to meet all seven grades of disaster. After all, the ultimate is only a matter of two more steps!

Disaster may come to any community at any time. To properly encompass the whole gamut of nursing service fields within this article, it has been necessary to select a community of approximately 50,000 persons — a city, in fact, that can boast not only of homes, a hospital, a hospital or university school of nursing and a public health service, but also of industries, schools, a visiting nurse service and, possibly, an official nursing office. Only by doing so could this material be presented on a "local community - nursing service field" basis since nurses work in or through all of the areas mentioned as existing in this particular community.

Miss Pepper is Nursing Consultant Emergency Health Services, Department of National Health and Welfare, Ottawa.

The following guidelines, prepared according to nursing service fields, should assist each nurse to act effectively *now* in order that she may serve her community to the best of her ability in an emergency.

The Nurse — Homemaker and Citizen

Whether a nurse is married or single, working at home or elsewhere, she usually has someone for whom she is responsible or who relies on her for advice or assistance. It has always been said, and rightly so, that one's first responsibility in an emergency is to one's family. This does not mean that you should wait until something happens before making any plans — it would be too late then. It does mean that you should make plans now for family action in case of an emergency.

If your work is such that you would not be able to return immediately to your family, you should realize this in advance. Make your plans in cooperation with a relative or good neighbor, someone who will act as your substitute and look after your children or folks along with her own. It is well to remember that families can become widely separated in a disaster situation. Consequently, one of the most important decisions to make, as a family, is where you would come together once the danger has passed. A predetermined rendezvous is a must. Other factors to be considered can be learned through reading the information that has been made available to the public. The chart on page 977 lists these publications and the source from which they can be obtained.

THIS IS YOUR CHECK LIST

Rx FOR SURVIVAL		11 Steps to Survival	Simpler Shelters	Your Basement Fall-out Shelter	Family Health Planning For Disaster	Your Basic List of First Aid Supplies	Welfare Tips For Survival	Your Emergency Pack	Protection of Your Family*
		Pages							
KNOW	EFFECTS OF NUCLEAR WEAPONS	4-9							
	FACTS ABOUT FALLOUT	10-15		pp. 20-25					
	LIFESAVING MEASURES	26-29							X
	WARNING SIGNALS	16-18							X
PREPARE	TRAINING					X			X
	FOOD AND MEDICAL SUPPLIES	22-25		pp. 29-32	X	X	X	X	X
	SHELTER	19-21	X	X					X
	PRIORITIES	19-39					X		

(Dept. of National Health and Welfare Emergency Health Services)

All publications are available through E.M.O., Box 10,000 in your province.

* *"Protection for your Family,"* The Canadian Nurse, *January, 1963.*

One of the great advantages of having an emergency plan is the sense of relief that it brings once the plan has been prepared. As Dr. Bernard Cohen of Harvard University once said, "You don't make values — you discover them."

The Nurse Administrator

This is an all-inclusive term representing the nurse in charge of our small hospitals — in the Western provinces they are usually referred to as "matrons" — as well as the directors of nursing in our large institutions. This person is the key nursing representative on the disaster planning committee. She is responsible for the development of all nursing arrangements within the framework of her hospital's plan. She may be the person responsible for putting the hospital's disaster plan into effect.

One nurse administrator's recent experience in activating her hospital's disaster plan can best describe how important it is for all nurses to understand this aspect of "disaster nursing."*

"Please remain calm. Stay in your room. The hospital will stand." These words of assurance came over the loudspeaker at Providence Hospital in Anchorage as the most violent earthquake in U.S. history shook the city's foundation on Friday, March 27, at 5:37 p.m.

The earthquake — and another that struck the southwest tip of Alaska two days later — devastated a large portion of southern Alaska. Tidal waves, spawned by the quakes, brought death and destruction to coastal areas in Alaska, Washington, Oregon, and California, and were felt as far away as Hawaii and Japan. Although it will be months before the complete loss in lives and property is known, unconfirmed estimates range from 50 to over 100 persons known dead, over 140 missing and presumed dead, and damage of $350 to $500 million.

Despite the shattering blows suffered by Providence, the modern, two-year-old hospital kept its promise. It not only remained standing, but within a few hours became the major emergency medical centre for the entire quake-stricken area of the state.

Sister Barbara Ellen, F.C.S.P., administrator of Providence Hospital, which is operated by the Sisters of Charity of Providence, ordered full-scale emergency operations put into effect immediately. According to John Hopkins, an Alaskan Blue Cross representative who was in the area

* *Trustee* — Published by the American Hospital Association. Vol. 17:5, May, 1964.

when the quake struck, the hospital had just recently been working on a revision of its disaster program. Complete staff meetings had been held to discuss the provisions of the new plan — a fact that contributed to the speed and ease with which work was carried out during the crisis. It was reported that many of the nursing service employees in the upper four nursing units had families, but not a single nurse, licensed practical nurse, or aide deserted her station.

Mr. Hopkins related that during the period from 6:00 p.m. on Friday until 7:00 a.m. on Saturday, 108 patients were received in the emergency room of the 155-bed hospital. It is estimated that another 50-75 patients received emergency treatment.

Within an hour after the 'quake, dozens of volunteer registered nurses, some of whom had not practised for many years, were in the hospital lobby waiting for orders. A group of physicians from Fairbanks chartered an aircraft and flew to Anchorage immediately after hearing of the disaster. The hospital was swamped with offers from medical personnel, and from persons wishing to donate drinking water purifiers, food, drugs, and other essentials. The Air Force responded immediately when the hospital requested that 80 emergency beds be set up on a standby basis.

Actual damage to the hospital was limited. Gas lines remained intact, but all electrical power was knocked out; there was no water supply; telephone ties to the outside world were dead; all internal communications, except for the loudspeaker, were inoperable. Within a short time, however, the auxiliary power plant went into action, supplying lights for the surgeries and main corridors. Fire trucks pumped water from a nearby creek to supply steam boilers and sanitary facilities. The army provided and manned emergency water supplies, supplied diesel fuel and a 100-kilowatt generator to operate kitchen equipment.

Since elevators had stopped running, casualties had to be carried by stretcher and litter to the nursing floors. It was late the following day before one elevator was put back into operation.

Screening and sorting of patients was carried out in the emergency department. The first patients were placed in a hallway on mattresses stripped from second floor beds.

Among the first to arrive were evacuees from Presbyterian Community Hospital, a 40-bed hospital situated in the severely damaged downtown Anchorage business district. By 6:30 p.m. Saturday casualties were arriving at all four entrances. Nurses and physicians from Presbyterian Hospital stayed at Providence to assist medical personnel.

All available doctors reported to the emergency department and were assigned to serve in surgery, X-ray, laboratory, fracture room, and on the floors. Dr. Don Val Langston, chief of the hospital's medical staff, directed the medical effort and Dr. Fred Hillman, chief of surgery, supervised surgeons. Sister Barbara Ellen and two assistants supervised the over-all effort. Victims' injuries ranged from severe to minor fractures; broken ribs; chipped bones; bruises, and strains. Other persons, many homeless and suffering from shock, sought out the hospital as a place of refuge. They were given coffee and a place to rest. One victim said, as he was being wheeled into surgery. "This hospital cost $6 million. Tonight, it would have been a bargain at 10 times that price."

On Saturday, 30 patients from St. Mary's Residence, a nursing home operated by the Sisters of Charity of Providence, were evacuated to Providence Hospital and to the Public Health Service Alaska Native Hospital.

Praising the work of hospital personnel and volunteers, Sister Barbara Ellen said:

> To single out any individual act of service or heroism would be a disservice to the hundreds who helped us. As far as I am concerned, it was a night when heroism and sacrifice were commonplace.
>
> The soldiers and airmen who provided every conceivable service and supplied every need; the electricians who repaired a pump to prevent flooding; the chaplains who gave last rites to the dying and comforted the injured; the cooks who made coffee and sandwiches; the radio operators who linked us with the city; the engineers who kept the water and power on — all must share Providence's victory along with Anchorage's dedicated doctors and nurses.

The emergency-inspired working arrangements and cooperation among hospitals reflected the unselfish spirit existing throughout the community. Evacuated Presbyterian Hospital offered food to St. Mary's Residence; the closed air force hospital provided supplies to Providence Hospital; the

Public Health Service Hospital provided typhoid serum to P.H. and, in turn, the latter sterilized surgical instruments for the PHS; the Alaska Psychiatric Institute did laundry for Providence.

This description of the Alaskan earthquake experience has been used because it was the most recent disaster affecting this continent. You are probably aware, however, that a number of *Canadian* nurse administrators have had to activate their hospital's "disaster plan." They have done so with similar confidence because they, too, had a workable, tested plan with which all staff members were familiar. Notable among these was Captain Eleanor Johnston, formerly of the Grace Hospital, Windsor, Ontario, whose hospital plan had to be put into effect on two occasions within the same number of years. If we could look into the offices of such nurse administrators, I am sure that we would see not only a copy of their plan but also a well-worn copy of the *Hospital Disaster Planning Manual*.

The Nurse Educator

"Disaster nursing" has been included in student nurse curricula by all provincial nurses' associations since 1958. Approximately 900 nurse instructors have been brought to the Civil Defence College, Arnprior for proper orientation in this subject. Some provinces have given additional support to disaster nursing by conducting comparable courses.

It would seem wise, and of benefit to the major groups concerned, for Emergency Health Services to ascertain now just how well disaster nursing is being integrated into the student nurse curricula of the 10 provinces. Only in this way can we assess what our next step should be in providing assistance to you, the instructors, who have been delegated the task of proper interpretation of disaster nursing. We are inclined to believe that we can retain the present level of this specialized instruction by conducting one course yearly in the English language and one course every two years in the French language. By initiating a survey this Fall, we hope to discover if our belief is correct. Nurse educators will doubtless accept this statement as an "alert."

It is hoped that the enthusiasm with which Emergency Health Services material was snapped up by students at the Canadian Nurses' Association biennial convention held in St. John's, Newfoundland, was a true expression of the interest and receptiveness of disaster nursing by our student nurse population. Between, the students with their "Ohs and ahs!" "These I must have!"; "May I have another set for my roommate back home?"; "I am a senior student and we will be reviewing disaster nursing in our final year"; "This is what we are studying right now" — nurse educators stopped to enquire if additional copies of the *Emergency War Surgery NATO Handbook* were available. Unfortunately this is limited to one copy per school. However, those nurse educators who did not receive a copy for their library are requested to write for one to: **Emergency Health Services, Tunney's Pasture, Ottawa. Attention: Nursing Consultant.**

Just a word of advice: the author is prompted to say this because of some of the student's remarks. Be careful that you do not integrate disaster nursing to the extent that it loses its identity in the mind of the student!

In a disaster situation nurse educators and their students are called into service immediately and in accordance with the hospital's disaster plan. The important thing for the individual nurse or student to know is *where* she is to report and *what* is expected of her when she gets there. The nurse educator should keep her students so informed. Also, it is extremely helpful if students can be exposed to a realistic exercise in order that they may "get the feel" of the disruption of their hospital's quiet, efficient calm, that can come with disaster.

There is nothing exotic or unusual about disaster nursing. The more one studies the subject the more one realizes that it is the application of good, practical, common sense nursing to intense, predetermined, nursing action and treatment.

The Public Health Nurse

An interesting development in emer-

gency health services education during the past few years has been the bringing together of public health personnel, including medical officers of health, laboratory directors, nurses, sanitary engineers, sanitary inspectors, and public health engineers to thrash out the role of this group and its individual members in a disaster situation. It has always been recognized that the public health service is one of the main services on which a community's disaster plan should be built.

One outcome of these multidiscipline courses was a pilot project on hospital experience, sponsored by the federal government on the request of 50 public health nurses of the Scarborough Department of Health. The syllabus was made up of didactic lectures, a refresher course in first aid, and 30 hours of hospital experience evenly divided between disaster nursing care and obstetrics. These latter arrangements were made possible through the cooperation of the Toronto East General Hospital. The complete 44-hour syllabus was carried out in the nurses' working hours. For the hospital experience portion, the nurses were divided into 13 groups and their time was staggered. In this way their official duties were in no way neglected and each nurse was given much more individual instruction and supervision as well as an opportunity to practise.

It has been the consensus of public health nurses, including those of the visiting nursing services, that in a disaster they would be called upon to give emergency nursing care during the immediate post-disaster period. This was substantiated throughout the pilot project. Consequently, included in the group's recommendations to their department was the suggestion that a centre be established through which public health nurses could receive similar beneficial and motivating training and experience.

The public health nurse has the advantage of a listening audience through her family-centred approach to her patients. She is a good candidate to motivate others to take first aid and home nursing instruction and to become familiar with the local community's plan for emergency. She is, in fact, a natural to teach home nursing.

The School Nurse

Like all other nurses, the school nurse should have a personal plan and should be familiar with her school's disaster plan. Most school authorities insist on regular, well-supervised fire drills as a basis for action in the event of any emergency. Such routine exercises ensure a disciplined evacuation of a school if the need arises. The principle of dispersal of students directly to their homes following evacuation has been widely accepted. If the students have been sent home, the school nurse might well be one of the first persons available to assist those in need following a disaster. It has been well recorded that this group has performed mammoth tasks, especially through mass immunization in stricken areas. However, like all other public health nurses, the school nurse should be prepared to do all types of emergency nursing.

At work she should encourage the inclusion of first aid and simple home care in the student's health education program. She can also stimulate parents to keep their own and the student's immunization up-to-date.

The Nurse Official

Once again, it is stressed that each nurse should have an emergency plan of her own. Officials who are responsible for staff should arrange for continuity of services in the event of disaster. Each employee on their staffs should know where she is to report and what she should do.

Canadian nurses will be pleased to know that, through the provincial nursing officials, confirmation of nurses' registrations have been microfilmed in duplicate, one copy of which will be placed in safekeeping by the federal government. In the event of mass disaster, this could prove to be a great security measure for any nurse who wishes to re-establish her position within her profession.

Nursing officials might well take on the responsibility of informing individual chapters concerning the advisability of keeping an active register of all nurses in any one community and propose a methodology for doing so.

Emergency measures personnel at community level would undoubtedly be grateful.

The Industrial Nurse

Every company, large or small, should have a workable emergency plan. You, as an employee, should know your assignment within the plan in detail. If you are employed in an essential industry, your responsibilities are more complex than those of nurses working in non-essential industries. These latter companies would possibly cease operation under vast disaster conditions and direct employees to aid others. The nurses from such companies would report to assist in the overall community health effort.

On the other hand, the nurse in essential industry would remain on the job. Of major importance would be the maintenance of health among the workers and the quick return to work of those who are injured or ill. This nurse should be highly trained in performing life-saving techniques. She should also be mindful of the special effects of a disaster within her plant due to the nature of the industry for which she works. The industrial nurse who finds herself working in a plant that has no disaster plan should be the initiator of action in this regard.

Conclusion

It is hoped that every nurse can find some direction in this paper applicable to herself and her position. It is hoped, too, that many nurses will be motivated to learn more about "disaster nursing," and its implications within the community plan; that they will assist the community by teaching more people to become self-reliant through home nursing preparation. *The best way to learn about disaster nursing is to become a part of it.*

A STUDY TOUR OF ENGLAND, DENMARK and FINLAND

DORIS SMALL

Our author continues the story of her study tour.

DENMARK

I left England in beautiful sunshine and, after an enjoyable flight, arrived in Copenhagen. I was whisked off to the Danish Nurses' Association where arrangements had been made for me to stay in an adjoining apartment block that provides individual accommodation for visitors. I found that it was used also for nurses who are on limited retirement incomes. A letter with my itinerary was posted on the key board in the entrance hall.

The letter welcomed me to Copenhagen and informed me that in rooms adjacent to mine were two other nurses on study tours — the nursing advisor of the Regional Hospital Board, London, and a public health nurse from Wales. My fellow tour companions were delightful women, and helped me considerably with my travel and eating arrangements. I had planned a trip to North Sealand to see the countryside and some of the historic landmarks. The tour took me through charming countryside with lakes, birch forests and small picturesque villages with flower gardens and rose-walled houses. The return trip was along the coast and commanded a beautiful view of Sweden. It was a thrill to see Kronberg Castle at Elsinore, which was said to be the setting for Shakespeare's *Hamlet*. Since the filming of *Hamlet* with Christopher Plummer in the title role was in progress we could

Mrs. Small is district director, Montreal Branch, Victorian Order of Nurses.

not visit the Castle, but we did see many of the cast in their costumes.

Next morning, Mrs. Borrild, the educational director who was in charge of my program briefed me concerning my visits. I went first to the Danish Mothers' Aid Centre in Copenhagen. These institutions are found throughout Denmark and came into being with the Mothers' Aid Act in 1939. The Centres are supported by public funds from the state and from the municipalities. Prior to 1939, Mothers' Aid was a private organization and, in Copenhagen, the private society is still in existence to cover costs that do not come under the state.

These centres come under the jurisdiction of the Ministry of Social Affairs, assisted by a council made up of members appointed from Parliament, from county organizations and municipal authorities.

Generally speaking the function of Mothers' Aid is to take care of every expectant mother who applies individually; to discover her problems and then, with her cooperation, to attempt to solve them. Purely medical problems are referred to the mother's general practitioner, since legislation passed in 1945 provides health and medical care examinations for all expectant mothers, medical examination of infants and children under seven years of age, and health visits to infants in their homes by public health nurses. Rehabilitation of the unmarried mother is receiving considerable attention. Economic aid is available for training or education.

Miss Norgaard, director of the Centre is a lawyer. The Centre is built around a court that contains a garden and recreational area. The building provides all of the necessary office and clinic facilities as well as apartments for unmarried or separated mothers and their children. This accommodation is available until the children are two years of age. There is a nursery that provides care for the infants while the mothers work. There is a kindergarten for the older children.

The nursery, with about 80 babies, fascinated me. It was immaculately clean and well-planned. Each baby had his own unit and attendant. It was a lovely day; the babies were all out-of-doors having their morning nap.

Educational courses, not only for the mothers but also for the fathers, are held spring and fall. They are conducted by pediatricians and public health nurses. There are mothers' clubs, with 15-20 members, that have social advisers or lawyers as leaders. The program is planned according to the clubs' needs and decisions.

My next visit was to the National Health Service headquarters where I renewed my acquaintance with Miss Magnusson, the chief supervisor of the nursing section of the National Health Service. These services are available to the entire population, and provide: free hospital treatment to all insured persons; free medical care to all those under a specified income level, while persons above that level are reimbursed for a substantial proportion of their expenses; free health supervision to expectant mothers and preschool children. There is also a school medical service. All employers are required by law to insure their workers against industrial accidents.

National old age pensions are payable to the entire population at 67 years (62 years for single women or married old age pensioners). The pensions are payable at rates that enable those who have no other income to maintain a reasonable standard of living on the pension alone. Any person in need of assistance and not covered by any social security scheme, is eligible for National Assistance without any form of socially degrading consequences. Social security schemes are financed largely through general taxation. According to the latest available data, the State paid 59 per cent of the cost of social services (including the National Health Service) administered through public channels or channels subject to public recognition. The local authorities paid 23 per cent, the insured 15 per cent and the employers 3 per cent. The total social expenditure amounted to about 13 per cent of the net national income. This background information was most helpful and necessary when visiting the various services.

Nurse education in Denmark, as elsewhere, is receiving considerable attention. At the present time, to qualify

for registration a nurse must first complete the preparatory nursing course that is available in specified folk high schools, or in the schools of nursing. This is followed by a three-year course in an approved school of nursing. All nurses are registered with the National Health Service and come under the supervision of the nursing section.

The nursing curriculum had recently been revised to include community aspects, both in theory and practice. The postgraduate school of nursing education is situated at the University of Arrhus and was established through the initiative of the Danish Council of Nurses and the National Health Service.

Fredericksberg Nursing Service

Visiting nurse service in Copenhagen started in 1870, not as a philanthropic agency, but as a kind of nursing care insurance. In 1957, following a study of the existing Home Nursing Services by a committee appointed by the Ministry of the Interior, the first Act of Home Nursing Care was passed in Denmark. This Act makes it compulsory for all local authorities to organize and provide home nursing care for all inhabitants within the area, regardless of income. The administration of the service may be delegated to visiting nurse agencies which was the situation in Fredericksberg.

Fredericksberg is an independent city, within the capital, with a population of approximately 117,000 people. The service originated in 1891 through the church. All social problems related to home nursing care are transferred by the local authorities for administration by the agency. This includes the Housewives Relief Scheme and Home Help.

The governing body consists of a committee of nine parish vicars plus two physicians, one lawyer and a finance officer. The nine parishes make small contributions, but expenses are the responsibility of the city of Fredericksberg. The staff numbered 26 including one male nurse and two nurses' aides. The visiting nurse works in close contact with the family doctor. She cares for the patient upon a doctor's order only. To qualify for employment a nurse must be registered and have taken the special six-month course provided by the Fredericksberg Visiting Nurse Association. Very soon all nurses will be required to take the public health course at Arrhus University. This preparation is now necessary for all positions of responsibility. In addition to this program all student nurses receive an introduction to district nursing during their second year. This introductory course is undergoing revision and, it was felt, would become much more comprehensive.

Inservice education is planned by the staff each year. Sessions are held at night. Attendance is not compulsory but the assistant director stated that there was almost 100 per cent attendance. A rotation period is planned with the Fredericksberg Hospital, where the district nurse goes for two weeks' experience on the ward of her choice. This rotation is valuable to keep the nurses informed of new treatments and drugs. I found that there was no financial problem; the payroll of the nursing association is in the hands of the hospital accounting department. Nursing equipment is provided through the local authorities; nurses use disposable equipment extensively.

The administration of Home Help is in a separate department. The chief supervisor told me that the service differs according to the area but is generally available. There are two types of helps.

The Housewives' Scheme is designed to relieve the homemaker when she is ill, either at home or in hospital, or when a single person is ill at home. The helper assists on an hourly basis and is supervised by the district nurse. These helpers have domestic training provided by the labor unions. There were about 60 housewives on the Fredericksberg roster.

The second type is for the aged and chronically ill, and permits the patient to remain at home. The helpers may provide continuous care, but duties and care vary according to the home situation. Many helpers are on a part-time basis. These workers, after one year of experience, receive a special course of 125 hours and are governed by definite regulations. There were about 90 on the register. The services are provided upon the requisition of the doctor, midwife or community nurses.

My visit to the official public health

nursing division was a worthwhile experience. While there are some differences, basically the individual services do not differ too much from ours. All public health nursing activities come under the various departments within the local organization which is responsible for establishing and maintaining the services. These services include:

1. *Mother and infant care:* Public health nurses do the home supervision and assist the general practitioner. Clinics are not held generally for infants other than for purposes of immunization. Antenatal and postnatal classes are held at the Mothers' Aid Centres.
2. *T.B. follow-up:* Public health nurses are attached to the T.B. hospital and outdoor clinic for follow-up in the community.
3. The *school health service* comes under the Board of Education.
4. *Industrial health nursing:* Each industry is responsible for its own nursing service.

The director of nursing said that there is a trend towards a more generalized program, especially in the more rural areas, and that this included visiting nurse service.

I realized the extent of decentralization in the over-all health program. Public health work is looked after locally by a communal council and centrally by various ministries, in particular by the Ministry of the Interior, but also by the Ministry of Social Affairs, of Agriculture, of Education, etc. In addition, there is the central medical board that supervises all health services and personnel, and has power and obligations to submit proposals for expanding and amending both health laws and administrative decisions.

Care of the Aged

This is the biggest individual item in the social budget. The services provided are a source of envy to many of us in the health field.

I spent a day at the old people's town. It has a population of 1,500-1,800 and is situated in the centre of Copenhagen in what was originally a hospital for the aged. The grounds are beautifully kept, and the whole place is a hive of activity.

The citizen is placed in the division that meets his individual needs. If independent, he and his wife are given a self-contained apartment in a modern building. He pays rent according to his income. There is a district nurse in residence.

For those who require limited care, there is an apartment-like building where each person has his own room and bath, furnished with his own belongings. On each floor there is a kitchen and lounge where the residents prepare snacks and entertain. The main dining room, where three full course meals are available, is attractively furnished with small tables. This room can be cleared for social activities.

I spoke to several of the citizens, all of whom expressed how comfortable they were, although they missed their own homes and friends. Since they could no longer manage alone, it was a comfort to them to have such pleasant surroundings and it was a great help to their families.

Active hospital care is provided in a modern hospital with all the latest facilities for physiotherapy and occupational activity. The occupational centre had the most modern facilities I have ever seen. Doorways, bathrooms, etc. were constructed so that patients could get around in wheel chairs, on walkers or crutches, and carry out the activities of daily living. Patients were busy with all types of activity: carpentry, furniture-making, weaving, rug-making, Christmas decorations, knitting, painting, etc. All finished articles are placed in their store and sold. This was an interesting spot for anyone who wished to purchase Danish tapestry, knitted wear, etc.

The administrator stated that they were proud of this particular set-up, but the trend is to maintain citizens in their own communities in self-contained homes or apartments. Housing has, and still is, receiving considerable attention, especially for the elderly and handicapped, at rents that they can afford. Space does not permit me to write about my social activities but I must mention that when I returned to my room each night, I found a thermos of coffee and a snack tastefully arranged on Copenhagen china and with a bouquet of fresh flowers.

Very early the next day I was at the airport to catch my flight for Helsinki

and the next stage of my program.

FINLAND

I felt very much at home here. The air and scenery were much like that of Northern Ontario. I was met at the terminus by Miss Koponen, executive secretary of the Finnish Nurses' Association, who had arranged my program, and Miss Volkonen, assistant director of the *Finnish Nursing Journal*, who helped me with arrangements for my transportation for the week. With her assistance and a good map, I spent the rest of the day acquainting myself with Helsinki.

The day after my arrival Miss Volkonen and I visited the National Park and outside museum. At my request she took me to the Childrens' Castle, now a treatment and educational centre for mentally disturbed children. I also had the opportunity to visit their new cancer treatment institute, probably one of the most up-to-date in the world.

Although 41.5 per cent of the population depends upon agriculture for a living, this accounts for only 11.9 per cent of the net national produce. Conditions for forestry are excellent; forests are the basis of the country's national economy. These are mainly in the hands of private owners, usually farmers, who depend upon them for an essential part of their income. Industry also plays a large role in the economy, especially the metal industry. Finland's lack of coal is partly compensated for by water power. No matter where you go there is building and road construction. New modern shopping centres are being constructed with good town planning in relation to schools, hospitals, churches and health centres.

As in the other Nordic countries, social insurance and social welfare schemes in Finland are developing into extensive social security programs. The highest authorities in health administration are the Ministry of the Interior and the Ministry for Social Affairs. Their activities, however, are limited to the legal and financial aspects of the program. The actual professional authority is vested in the State Medical Board.

Finland is divided into 12 provinces with 552 rural and urban communes. The commune is the smallest administrative unit. Public health work in a commune is directed and supervised by the communal board of health. In urban communes, the board employs one to four health officers, in rural areas one or two. Their duties include both preventive health work and treating the sick. They direct the local health team consisting of one or more public health nurses, midwives and sanitary inspectors, and supervise the work of the local maternity and child health centres. They are also responsible for the school health service. Many communes have a small hospital, also headed by the chief health officer. In addition, he is the physician of the local home for the aged and disabled. Larger towns and cities have their own general and mental hospitals. Adjacent communes sometimes form federations for the joint administration of larger local hospitals. The state serum institute and other bacteriological laboratories, the schools of nursing and of midwifery, pharmaceutical products and drug factories are all directly under the authority of the State Medical Board.

Miss Terola, chief of the Public Health Nursing Division, outlined nursing administration. Directly under her control are 20 supervisors who are responsible for the public health nursing program. There is a ratio of one public health nurse to 4,000 population. All nurses are qualified in public health having had one year of postgraduate study. Salaries are set by the State Medical Board; three-quarters is paid by the state and one-quarter by the commune. In the more isolated areas the salary rate is much higher, especially in the northern areas. Each commune has its health centre and many have separate living arrangements for the staff. This is changing due to the fact that 60 per cent of the public health nursing staff is married.

The public health nursing program is generalized and includes visiting nursing. The latter was causing concern since they were not meeting this need.

The home help service is not under the administration of the nursing sec-

tion but is set up under its own division with a training program. The service is available throughout the country.

After visiting the State Medical Board, I spent two days at the Uusimma Health Division. Uusimma is a large province adjacent to Helsinki. It also has the chief teaching centre which was established originally with a grant from the Rockefeller Foundation and was maintained by the Foundation until 1957 when the state took it over. The province has four towns, seven market towns, and 34 rural communes. Each community has its maternity and child health centre. The total health personnel consists of 42 medical health officers; 103 public health nurses; 78 midwives; 37 sanitary inspectors. The staff also includes consultants in the fields of child health, maternity care, mental hygiene, nutrition, psychiatric nursing, and social work. Working full or part-time, their task is to act as trainers and advisers in their particular fields for all personnel in the province.

The in-service training of field personnel is looked after by the provincial health office with the help of the consultants. In addition, each training institute supervises the field experience of its students.

An opportunity was provided to visit one of the maternity and child health centres at Mattby. At this new and very modern centre there were three public health nurses and two public health nurse midwives. Adjacent to the centre was a modern nursery school. Health supervision was provided by a public health nurse. Mattby is a very progressive and expanding area, suburban and in a favorable financial bracket. I accompanied my guide to one of her schools where all of the grade one students were examined by the doctor. Special attention was paid to posture, feet and teeth. The children were the picture of health.

All children receive their lunch at school. I was invited for what they called "porridge" at 11:00 a.m. I was taken to the kitchen where all the food is prepared under the direction of a nutritionist. The children were to have farina cooked with fruit — on this occasion it was apricots. It is eaten hot or cold with milk and sugar. In addition, there was the Scandinavian open sandwich — large slices of brown bread and meat — with all of the milk that they could drink.

The doctor in attendance had a very busy private practice in addition to his duties as medical officer of health. There is a shortage of doctors and public health nurses in Finland. This is not due to lack of applicants, but to the rapid expansion of health services and the lag in medical and nursing educational facilities.

From the school, we went to another health centre which was situated in a very modern housing area and shopping centre. The public health nurse in charge said that this centre was really much too busy for the available personnel. It was not possible to visit the homes as much as was essential. The nurse-midwife was conducting a clinic where each mother received a complete layette in a bassinette.

Nursing education is under the State Medical Board and is conducted in 23 independent schools of nursing. Students pay for their uniforms and living accommodation. Each school has a board of directors appointed by the State Medical Board. The schools are administered by a nursing director and her assistant. The course is two and one half years in length. Following graduation, each nurse is registered with the State Medical Board. In addition to the basic course, there are six state schools for postgraduate study in public health and clinical specialties. Helsinki College of Nursing is at present the only school to offer courses in all specialties.

The vitality of the Finnish people and their fresh or novel approach to situations impressed me. Native handicraft was evident in every home. Often, in offices, you would find a low round table and chairs by the window, with a bouquet of flowers. I was never interviewed sitting across a desk. Again in Finland, I had the company of a nurse from Britain. Before bidding au revoir to Finland we decided to experience the native sauna. My one regret was that time did not permit me to visit the northern part of Finland and make the acquaintance of the Laplanders.

THE WORLD OF NURSING

PREPARED IN YOUR NATIONAL OFFICE, CANADIAN NURSES' ASSOCIATION,
74 STANLEY AVENUE, OTTAWA

Student Admissions on the Rise in New Brunswick

Four hundred and sixty-seven students were admitted to schools of nursing in New Brunswick in 1963. This is the largest admission on record. Three hundred and eighty-three were admitted in 1962, and 328 in 1961, making a total of 1,178 in the past three years. Of this number, 154 have withdrawn, leaving a total of 1,024. The senior class of the U.N.B. school, admitted in 1960, brings the total to 1,037 students presently in schools of nursing in New Brunswick.

Short-Term Courses help Bridge the Gap

A U.S. Department of Health, Education and Welfare release reveals that over 24,000 registered nurses have studied under the Public Health Service Professional Nurse Traineeship Program since its start in 1956. Of these, 10,000 have pursued full-time academic study at colleges and universities to prepare for teaching and administration, while about 14,000 have had short-term intensive courses to improve and up-date their nursing skills.

The release points out that the training of nurses is a national concern because nurses now require more knowledge than ever before to be able to use the advanced techniques which modern medical science makes possible.

"Short-term intensive courses are helping to bridge the gap between yesterday's training and today's needs," says the release. For example, a course on cardiac nursing gave the nurse supervisors and teachers who attended their first opportunity to work with the heart-lung machine and with patients who had undergone open-heart surgery. Nurse teachers who attended a course on the scientific principles underlying all disease said they had an improved understanding of shock and stress and were able to focus more clearly on the ultimate objectives of medical care. An intensive short-term course in mental health practice afforded daily experience in a psychiatric hospital. Half of the participants had no previous instruction in caring for the mentally ill.

Descriptive listings of scheduled short-term courses and a list of colleges and universities offering full-time academic study under the Professional Nurse Traineeship Program are available on request from the Training Grants Branch, Division of Nursing, U.S. Public Health Service, Washington 25, D.C.

International Associations Offer Study Programs

The National Nurses' Associations of Denmark, The Netherlands and the United Kingdom are offering study programs and tours either before or after the meetings, to delegates to the Congress of the International Council of Nurses next June.

In Denmark, programs are being offered in:

Administration
Education
General hospital nursing

Psychiatry
Geriatrics and care of the chronic sick
Occupational therapy and rehabilitation
Public health
Domiciliary nursing
Hospital planning

Interested nurses should contact the Danish Nurses' Association, 1 Fensmarkgade, Copenhagen, not later than January 1, 1965, giving their field of interest, studies wanted in and/or outside Copenhagen, date of arrival and departure, the first and last day of study and address while in Copenhagen.

In the Netherlands, programs are being offered in:

Psychiatric nursing
General nursing
Geriatric nursing
Pediatric nursing
Chronic sick and rehabilitation
Public health nursing
Administration
Education

The National Nurses' Association of The Netherlands would like to hear from those interested before December 1, 1964, with field of interest and the exact date of arrival and departure. The Association's address in The Netherlands is, Frans Halsstraat 23, Haarlem.

In the United Kingdom, individual visits can be arranged as required in London or other parts of the United Kingdom. The Association is also offering the following organized tours:

1. *Four Country Tour* (Air) 14 days. Cost 92 Pounds Sterling. This tour, July 5 to 19, includes three days in London, Edinburgh, Belfast and Cardiff.

2. *West Country Tour* (Coach) 11 days. Cost 62 Pounds Sterling. This tour, July 5 to 15 or July 13 to 23, includes visits to Sussex, Devon, Cornwall and Somerset.

3. *North Country Tour* (Coach) 10 days. Cost 57 Pounds Sterling. This tour, July 5 to 14 or July 13 to 22, includes visits to Manchester, York, Durham, Newcastle-on-Tyne and the Lake District.

4. *Home County Tour* (Coach) 8 days. Cost 49 Pounds Sterling. This tour, July 5 to 12 or July 13 to 20, includes visits to Oxford, Stratford-on-Avon, Birmingham and Coventry.

5. *Day Tour to Cambridge* (Coach). Cost 4 Pounds Sterling. This mid-week tour includes visits to Colleges and hospitals.

6. *Day Tour to Oxford* (Coach). Cost 4 Pounds Sterling. This mid-week tour includes visits to the Colleges and hospitals.

All the tours will begin and end in London at the Royal College of Nursing. Short explanatory talks will be given on the various health services in the United Kingdom, to include community care and hospital in all branches, and a "question and answers" session will be held at the RCN for each group. The object of the tours is both professional and cultural. Those participating will have an opportunity of seeing some of the beauty spots of the United Kingdom as well as places of professional interest. A member of the profession will accompany all groups.

Accommodation on the tours will be in good hotels and all meals will be provided daily.

Cost may need to be adjusted between now and next year. The prices quoted are those applicable at the time of writing.

Deposit of 5 Pounds Sterling will be required for any of the organized tours, which includes insurance, cancellation protection and 1 Pound Sterling towards administrative costs.

Balance of Payment must be paid to Messrs. Challis and Benson Limited, 133 New Bond Street, Mayfair, London, W.1, England, not later than May 7, 1965.

Confirmation of Participation in one of the tours must be received by the International Department, RCN, Henrietta Place, Cavendish Square, London, W.1, England, not later than November 1, 1964, if possible.

Application forms for the tours may be obtained from the International Department, RCN.

Study Scholarship for New Zealand Nurses

The pharmaceutical house of Smith & Nephew (NZ) Limited has announced that a scholarship valued at two thousand Pounds Sterling will be given each five years to enable New Zealand nurses to undertake postgraduate study in any commonwealth country. The scholarship is to be administered by the New Zealand Registered Nurses' Association.

Speak softly and carry a big stick; you will go far. THEODORE ROOSEVELT

Recommendations for Nursing

The following extracts, relating to nursing, are from the Report of the Royal Commission on Health Services.

1. That there be established in each province a Nursing Education Planning Committee, advisory to the Minister of Health, to plan and direct the gradual and orderly development of nursing education. The Committee should be representative of the Provincial Nurses' Association, the Hospital Associations, University(ies), the Hospital Insurance agency, and the Department of Education.

2. That the budgets of the Schools of Nursing operated by hospitals be separated from that of the Nursing Service of the hospital to the end that the Schools of Nursing become wholly educational in their function.

3. That hospitals make their educational and clinical facilities available for the instruction and clinical experience of students, without claim on the student for service.

4. That these Schools of Nursing reorganize their curricula to provide for graduation with a diploma in two years, and that, where necessary, provincial legislation be amended to provide for licensing of the graduate as a registered nurse on the successful completion of examinations following the two-year course.

5. That to encourage suitable personnel to enter and remain in the nursing profession, salaries commensurate with the training and responsibilities of nurses and comparable with those in similar fields be paid by federal and provincial agencies and by hospitals.

6. That financial assistance be provided to student nurses in hospital schools in the same amounts and under the same conditions as those for students in other fields in the hospital.

7. That consideration be given to supporting only those schools of a sufficiently large size that will permit most effective utilization of qualified teaching personnel and financial resources.

8. That all University Schools of Nursing develop an integrated degree programme and direct all phases of this programme. At least one University School in each of Canada's four main regions should also develop a Master's degree programme in nursing, one of which should be a French language school.

9. That the existing University Schools of Nursing be expanded to their optimum capacity and that federal capital grants from the Health Facilities Development Fund and federal operating grants from the Health Professions Education Grant be available to them.

10. That there be established as quickly as qualified personnel can be recruited at least ten more university schools to expand the annual output of university graduate nurses, and that funds be allocated from the Health Facilities Development Fund to provide one-half the cost of establishing these schools. We believe these ten schools can be established in about five years. Among the universities where these might be provided as additional faculties are: University of Victoria, University of Alberta (Calgary), University of Saskatchewan (Regina), Laurentian University, York University, Carleton University, Université Laval, Université de Sherbrooke, Université de Moncton, Memorial University. Given time for them to become fully established, (say, 1971) the 24 schools then operating could, with an average enrolment of 225, produce approximately 1,200 graduates annually.

11. That as part of a seven-year crash programme, Professional Training Grant bursaries of $3,500 be made available so that more graduate nurses having the baccalaureate degree be enabled to obtain the Nurses wishing to enrol for a Bachelor's de- for appointment as university instructors.

12. That as part of the same seven-year crash programme, Professional Training Grant bursaries to the amount of $2,000 be made available immediately to Registered Nurses wishing to enrol for a Bachelor's degree in nursing in university schools of nursing.

13. That the present Professional Training Grant bursaries be expanded in number to enable more diploma nurses to obtain certification in public health nursing.

14. That when the diploma course is shortened to two years, the training period of the nursing assistant be shortened cor-

respondingly. Meanwhile, a study should be made of the feasibility of training the nursing assistants on the job.

15. That in view of the need for male nurses in the health field, efforts be made to attract men to the nursing profession.

16. That in order to provide a continuous uninterrupted supply of qualified operating room technicians, a new classification of this type of work be established with adequate salaries so that men may make a career of this occupation.

Canadian Nurses' Foundation

The Foundation, which came into being in 1962 with the approval of the CNA membership, is presently in its second year of operation. Its purpose is essentially a very simple one — to prepare nurses academically for positions of leadership within the profession. The W. K. Kellogg Foundation contributed $150,000 to be used entirely for scholarships and grants-in-aid — this sum to be made available over a six-year period. Naturally, the aim and the hope of the Foundation is that Canadian nurses will subscribe to and support the project so that it can become entirely self-supporting and so that its objectives can be achieved.

The first year of activities saw 11 CNF scholars proceeding with studies at the Master's level. This year six nurses have received awards to study in Master's programs, while four are proceeding to their doctorates.

Master's level:

1. **Kathleen E. Arpin** is enrolled in a two-year program at Boston University where she intends to major in the administration of educational programs. She is preparing for the position of assistant director, nursing education, School of Nursing, Toronto General Hospital.

2. **Lorine Besel** will study for a Master of Science degree with a major in psychiatric nursing at Boston University.

3. **John Michael Binas** is enrolled at Boston University as well. His major is to be clinical adult psychiatric nursing.

4. **Clara May Lennie** is studying for her Master's degree in nursing administration at the University of Washington. She is preparing for an administrative position at the Royal Alexandra Hospital, Edmonton.

5. **Myrtle A. Kutschke** intends to major in medical-surgical nursing and will study at Boston University.

6. Mrs. **Margaret S. Neylan** is majoring in adult education as part of her Master of Arts program at the University of British Columbia. She is preparing for a teaching position in a university school of nursing.

Doctoral level:

1. **Margaret C. Cahoon** is completing her doctorate in education at the University of Michigan with a major in health education. She will return to the School of Hygiene, University of Toronto as associate professor.

2. **Shirley R. Good** is enrolled in a two-year program at Teachers College, Columbia University. She plans to major in teaching as part of her doctoral program, in preparation for a position as university lecturer.

3. **Margaret L. Hayward** will follow a two-year program of study at the University of Pittsburg to obtain her Ph.D. She will major in graduate education in preparation for a university faculty position.

4. **Margaret N. Lee** will study for her doctorate in education at Teachers College, Columbia University, in preparation for a university faculty position.

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Nursing Profiles

The Ottawa Civic Hospital recently welcomed its new director of nursing who is, for the first time in its history, a graduate of its own school of nursing. **B. Jean Milligan**, a 1942 graduate who has been in



(Paul Horsdal, Ltd. Ottawa)

B. JEAN MILLIGAN

charge of the School since 1950, was named to the position of assistant director of the hospital and administrator of the nursing department, replacing **Edith G. Young** who retired at the end of last July. Miss Milligan also has the distinction of being just the third director of nursing that the Civic Hospital has had since its doors opened in 1924.

The new director received a Bachelor of Nursing degree from McGill University in 1950 and completed requirements for her Master of Arts from Teachers College, Columbia University in 1962. In addition to her duties with the School of Nursing, she has also been in charge of the course for nursing assistants that was started in 1960. She has found time as well for participation in many community organizations including the St. John Ambulance Association, the Canadian Red Cross Society, the local Quota Club and University Women's Club. Miss Milligan is the first vice-president of the Ottawa Chapter, RNAO.

When **Edith Grace Young** first came to the Ottawa Civic Hospital as director of nursing in 1946, she had already developed an impressive background of administrative experience. Eighteen years later, it can be said with justification that she must surely be one of the most knowledgeable people in Canada in the field of hospital administration.



(Thomas Studio)

EDITH G. YOUNG

Miss Young graduated from the Lady Stanley Institute, Ottawa in 1922 and spent the following four and one-half years as superintendent of Rosamond Memorial Hospital, Almonte, Ont. — now the Almonte General Hospital. This was later succeeded by her appointment as instructor of nursing, Nicholls Hospital, Peterborough, Ont. (now Peterborough Civic Hospital) where she eventually rose to become superintendent of nursing in 1940. She found time in these busy years to secure her diploma in nursing education from the School for Graduate Nurses, McGill University and to spend four months in observation at hospitals in London and Edinburgh.

Her record of achievement at Ottawa Civic Hospital has been characterized by a spirit of progressiveness and initiative. This can perhaps be most aptly illustrated by the fact that the School of Nursing expanded from 150 students in 1946 to approx-

imately 500 in 1964; that the School for Registered Nursing Assistants — the first to be established in Canada in connection with a school for professional nurses — opened in 1960.

Miss Young's retirement from her administrative duties at OCH leaves her free for a broader field of service, sharing her knowledge with other nursing administrators across the country.



(The Musical Clock, St. John's)

JUNE FAIRLEY

June (Andrews) Fairley has been appointed associate director, nursing service, St. John's General Hospital, Newfoundland. A 1957 graduate of the school of nursing attached to the same institution, Mrs. Fairley studied public health at the University of Toronto. She has had several years of experience in the field of nursing education, first as nursing arts instructor, later as clinical instructor in pediatric nursing, SJGH.

Mrs. Fairley was president of the St. John's Chapter, ARNN, 1963-64; is a member of the executive of her alumnae association and served as chairman of the Ways and Means Committee, ARNN.

Holy Family Hospital, Prince Albert, Sask. announced the appointment of **Sister Albert Marie** as associate director of nursing service earlier this year. A graduate of Hotel Dieu Hospital, Edmundston, N.B., Sister obtained her B.S.N. from the University of Ottawa. Her most recent position prior to her present one was at St. Joseph's Hospital, Saint John, N.B. In addition she has had experience in nursing service in hospitals in Ontario, and Michigan, U.S.A.



SISTER ALBERT MARIE

The new director of nursing education at Victoria General Hospital, Winnipeg, is **Dorothy M. Dick.** She took over her new duties earlier this year following several years as clinical coordinator, Winnipeg General Hospital.

Miss Dick is a graduate of Royal Victoria Hospital, Montreal. She studied public health nursing at McGill University and later obtained her B.Sc. degree from Teachers College, Columbia University. In 1954 she fulfilled requirements for her M.A. from the same institution. In addition to general staff experience in both the hospital and public health fields, Miss Dick was an instructor in the school of nursing, University of Manitoba for several years. She was chairman of the MARN public health nursing committee for two years; president of District I association for the same length of time and also served on the provincial nursing service committee.

The New Brunswick Association of Registered Nurses has announced the appointment of **Marilyn Jean (Dodd) Brewer** as its public relations secretary. A graduate of the school of nursing, University of Toronto, Mrs. Brewer has been engaged in public health nursing with the N.B. Department of Health since November 1961. Prior

to this she was on the staff of New Mount Sinai Hospital, Toronto.



MARILYN J. BREWER

Mrs. Brewer has taken an active part in the activities of the NBARN. She is presently first vice-president of the Fredericton chapter and has served on various provincial committees. In her new public relations role, she will work closely with all ten chapters and with the public relations committee of the Association. She will act as editor of the *News Bulletin* that is published three or four times yearly.

Every good wish is extended to her for continued success and happiness in her new position.

When **Edith R. Dick** retired from the Ontario Department of Health earlier this year, she had completed 32 years on the staff of the Department — 29 of them in the Nursing Branch, the last 17 of which were spent as director of the Branch. The war years, 1940-45, interrupted her work while she served with the RCAMC in Canada, England and France. In 1944 she was awarded the Royal Red Cross in recognition of her contribution. It was following her return to civilian life that she was made director of the Nursing Branch. The years 1947-64 brought extensive development within the Branch. The inspection staff increased from one to six nurses, covering 62 schools of nursing and 40 centres for the preparation of nursing assistants. With the establishment of the Ontario College of Nurses, responsibility for the inspection of such schools was shifted to this body.

Miss Dick is a graduate of Johns Hopkins Hospital, Baltimore, with her Bachelor of Arts from the University of Toronto. She studied public health nursing at U. of T. as well.



(Ballard & Jarrett, Toronto)

EDITH R. DICK

She has set an impressive record of service to her profession and, in so doing, has gained the respect and admiration of all those with whom she was associated. Retirement, it is hoped, will bring with it other satisfactions for which a busy professional life left a minimum of time. To Miss Dick we extend very warm good wishes for the future and congratulations on an outstanding career of professional achievement.

Elsie C. Ogilvie, a faculty member of the school of nursing, University of Toronto, since 1956, retired from active nursing at the end of August. A graduate of Grace Hospital, Toronto, Miss Ogilvie studied administration in schools of nursing at McGill University and was appointed assistant director of nursing at the Neurological Institute, Columbia Presbyterian Medical Centre, New York. Later she held administrative positions, including that of director of nursing, at the Institute for Living, Hartford, Conn. Highly experienced in the field of psychiatric nursing, Miss Ogilvie later returned to Canada and organized a course in supervision in this specialty in connection with the McGill School for Graduate Nurses. Eventually she joined the Department of National Health and Welfare as consultant in mental health nursing and

carried out a survey of nursing needs in mental hospitals across the country. This appointment succeeded her experience as a nursing consultant with the American Psychiatric Association. Miss Ogilvie plans to make her home in Lakefield, Ontario. Friends and colleagues will join in good wishes for happiness in her new life.

NAMES IN THE NEWS

Elizabeth Anne Murray, a graduate of the University of British Columbia School of Nursing in 1959, joined the RNAO as its public relations secretary earlier this year. She was a public health nurse in Toronto for two years following graduation before joining The Kendall Company (Canada) Limited as nurse consultant, leaving there to assume her present duties The new superintendent-in-chief of the St. John Ambulance Brigade, Women's Branch, is **Mrs. Peter Robinson.** She is a former national president of the I.O.D.E. A total of 15 student and graduate nurses were selected from more than 70 applicants across the country to receive bursaries from the St. John Ambulance Association. **Catherine Enns**, a graduate of Winnipeg General Hospital, received the top award for study towards her Master's degree. This award was drawn from the newly established Margaret MacLaren Bursary Fund. **Raymonde Pelletier** and **Evelyn Egers**, both of Fredericton, and **Carol Steeves**, Moncton, also received awards from the same fund.

Alberta McColl, a graduate of Regina General Hospital, received the highest Countess Mountbatten bursary for study towards her Master's degree. **Aileen Hagger**, St. Joseph's General Hospital, Port Arthur; **Celine Bourgeois**, a graduate of Hotel Dieu Hospital, Montreal; **Dorothy Arthurs**, Montreal; **Judith Benjamin**, Halifax; **Donald Brown**, Nipawin, Sask. and **Borden Petriw**, St. Boniface, Man. were the other recipients of the awards.

In Memoriam

Mariette Bouchard '29, **Jeanne (Desrosiers) Dunlop** '34, Notre Dame Hospital, Montreal.

Moira (MacTavish) Coughlan, Jeffery Hale Hospital, Quebec.

Mary Elizabeth (Gay) Chartran '35, Oshawa General Hospital, Ont.

Ina (McCutcheon) Chillingworth '05, **Louise F. (MacLeod) Cleaveland** '08, **A. M. (Malloch) Grindley** '05, **Olive H. Wilson** '32, Montreal General Hospital, Montreal.

Margaret E. Flanagan '28, St. Joseph's Hospital, Port Arthur, Ont.

Mary H. Goodfellow '43, **Mary Alexandra Lockhart** '38, Royal Victoria Hospital, Montreal.

Rosa Marie Huck '24, Grey Nuns' Hospital, Regina.

Lenore Elizabeth (Rose) Kane '15, Brockville General Hospital, Ont.

Dorothy Vivien (Boughton) Lodge '37, Royal Jubilee Hospital, Victoria.

Pearl Elizabeth (Dixon) MacKinnon '41, Soldiers' Memorial Hospital, Orillia, Ont.

Mary Lamble Shortreed '31, Royal Alexandra Hospital, Fergus, Ont.

Sister Marie Aloysia Sullivan, Halifax Infirmary, Halifax.

Dorothy Jean (Sanderson) Stetler '35, Toronto General Hospital, Ont.

Madeline S. Taylor (Montreal General Hospital, '23) died on June 4, 1964, after a long illness. Prior to World War II, she organized and supervised the Regina Branch, Victorian Order of Nurses, then returned to Montreal and a supervisory position with the Order. Miss Taylor joined the RCAMC in 1941 and was attached to No. 14 Canadian General Hospital. She served in England and Italy, in the latter country as matron of No. 11 British General Hospital. In 1945 she was posted to Germany as a member of UNRRA. Upon her return to Canada, Miss Taylor was appointed Matron of the Displaced Persons Reception Centre and later, director of organization, Quebec Cancer Society. Prior to her final illness, she was with the Department of Indian Affairs, Alta.

Nursing Auxiliary Programs

KATHLEEN A. DIER, M.SC.

This is a report of a survey undertaken to determine the number of English-speaking auxiliary schools in Canada, their location and the types of courses taught. An attempt was also made to learn something about the students enrolled in the programs.

Because of the rapid increase of nursing auxiliary schools after World War II, the Canadian Nurses' Association drew up a "Suggested Curriculum Guide," revised it in 1956 and made it available to any school desiring assistance with its program. Meanwhile, in the United States, the rapidly expanding auxiliary group broke away from the main body of nursing, formed their own practical nurse organization, and are now pressing for representation on the State Board for Practical Nurse Examinations. The National League of Nursing is opposed to this but has agreed to help develop postgraduate courses for practical nurses. Recently, in Canada, Dr. D. R. Brown suggested that nursing auxiliaries should take a postgraduate course in a particular specialty.*

Definition of Terms

Nursing Auxiliary — One who has received formal training from an institution recognized by the provincial nurses' association. This title includes nursing assistant, nursing aide and practical nurse.

Vocational Schools — Where the classes are conducted in an area set aside for educational purposes.

Hospital Schools — Where the teaching is done in the hospital. These include mental, T.B., maternity, chronic and general hospitals.

Methodology

The names of 72 recognized schools were obtained from the ten provincial nurses' associations and a questionnaire was sent to each. The findings of this survey are based on the replies from 60 schools.

Findings

Of the 72 schools listed, 17 were vocational schools while 55 were hospital schools.

Legislation:

Seven provinces have legislation governing the practice of nursing auxiliaries. In Saskatchewan, Ontario and New Brunswick, it is incorporated into the Nurses' Acts. Alberta, Manitoba, Nova Scotia and Prince Edward Island have separate acts for nursing auxiliaries. In Manitoba and Prince Edward Island, the students write the American Licensed Practical Nurse examinations. British Columbia has legislation which has not been implemented while Quebec and Newfoundland have none as yet. In all provinces, the Registered Nurses' Associations have representation on nursing auxiliary educational boards either in an official or advisory capacity.

Types of Courses:

Three hospital schools in Ontario offer 12-month night courses — eight months of night lectures and four full months of clinical experience. Two mental hospitals in Manitoba have a three-year program. Their students write both the psychiatric nurse and the licensed practical nurse examinations. There are two collegiate programs in Ontario that are conducted in high schools. They are two academic years in length with integrated hospital

Miss Dier prepared this report while attending the McGill School for Graduate Nurses, Montreal, in 1963.

* David R. Brown. "The Nursing Assistant," *The Canadian Nurse*, Vol. 58, p. 1102, (Dec. 1962).

TABLE I

Mean Length of Nursing Auxiliary Courses and the Distribution of Classroom and Clinical Time as Compared to the "CNA Suggested Curriculum."

	Range	*Mean*	*CNA Recommendations*
Classroom	5-36 weeks	14 weeks	3 months (14 weeks)
Clinical	12-46 weeks	29 weeks	6 months (27 weeks)
Length of course	37-74 weeks	46 weeks	9 months (41 weeks)

experience. The general format of the remaining courses can be seen in Table I.

Growth of Schools:

Figures indicated a rapid increase in the number of students graduating, particularly from vocational schools. In 1958, 897 students graduated from all auxiliary programs in Canada; in 1961, the number rose to 2,034.

There has been a marked increase in the number of such schools, particularly hospital schools, since the introduction of hospital insurance.

Type of Student:

The "ideal" student, as described by respondents, is female, between the ages of 20-25 and single — although many schools indicated that they had no preference about marital status. The preferred candidate has a Grade 10 education, an average I.Q., and comes from a small town where her family is in medium income group. There was no great discrepancy between this "ideal" and the majority of students now in the schools.

Thirteen per cent of the schools stated that their students lived in; 63 per cent required that the students live out; in the remaining 24 per cent it was optional. Forty-seven per cent of the schools will accept male students.

Costs:

Since it is difficult to estimate actual cost, the following figures are approximate. The reported cost per student graduating was estimated from $50 to $2,000, both the highest and lowest in this range being in Ontario. The mean cost across Canada was $1,065 per student; the average for vocational schools alone was $974, the most economical being the night courses averaging $750 per student. These figures do not include the three-year psychiatric courses or the two-year collegiate programs.

The pattern of payment to the students varied from no stipend in one collegiate school to $90 per month during the entire course in one hospital school; most schools paid $70 per month if the student lived out and $10 per month if she lived in. It was indicated that the money was budgeted for through vocational training and, in the clinical period, through hospital insurance. Psychiatric programs were not included in this study of costs since their payments are higher, more in the form of salary for service.

Courses:

The instruction period varied from 186 to 570 hours, the mean being 350. This does not include the 3-year psychiatric hospital programs that are more extensive and not comparable.

There were indications that the curriculum had been revised since courses such as emergency nursing, medical-surgical nursing, ethics and relationships, bacteriology, drugs and solutions, and psychiatry were frequently added. The lists of procedures varied, the problem areas being mainly in the administration of drugs, both orally and by injection, and the recording of blood pressures. There was general agreement that the students should not carry out procedures involving extensive sterile technique or be expected to handle complex equipment.

In the clinical areas, the students' experience was usually confined to medical-surgical, maternity, pediatrics, geriatrics and nursery areas. Some schools added community agencies and specialized departments while others indicated that these services were beyond the scope of the nursing auxiliary.

Of the 30 textbooks listed specifically for nursing auxiliaries, the most

popular, Thompson and LeBaron's *Simplified Nursing*, was being used in 35 schools. A few schools subscribed to either the *Practical Nursing Journal* or the *Practical Nurse Digest*.

Forty-one per cent of the schools did not place their students on evening duty; 58 per cent did not require them to do night duty. In the remaining schools the average amount of time spent on each shift was approximately two weeks. In all but four schools the students worked a 40-hour week, often less during the preclinical term.

Role Confusion:

The CNA *Suggested Curriculum* states that if the nursing auxiliary is to be used to the best advantage "it is essential that there be a thorough understanding of her role." Of the 42 schools that stated philosophies, only three attempted to delineate the "role of the auxiliary," the others spoke of nursing in its entirety.

Furthermore, the comments of teachers reflected confusion. The majority were in favor of further training for auxiliaries while the remainder advocated that the auxiliary should remain at the bedside and give the care for which she was trained. A few questioned the difference between an auxiliary with postgraduate training and registered nurse from a three-year program. Some contended that the auxiliaries should be given more pay and prestige but many complained that they were already accepting too much responsibility and were often being used as "cheap nurses."

In appearance, it is increasingly difficult to distinguish a nursing auxiliary from an R.N. Initially, auxiliaries wore colored uniforms; now, most provinces sanction white uniforms with a flash on the sleeve and a white cap with a colored band for graduates. It appears that many schools and employers are indifferent to what is worn. Dr. Robert Merton sees this attempt to identify more closely with the registered nurse as one reason why the practical nurses in the United States are trying to achieve more status. Auxiliary nurses have a limited upward mobility as by definition they must work under the supervision of a registered nurse. The practical nurses

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have reacted to this by forming a separate pressure group to obtain more autonomy. The Canadian auxiliaries have organizations in five provinces but as yet have no national body.

Summary and Conclusions

It would appear that there are some contradictions in nursing auxiliary education in Canada. In spite of the fact that vocational schools are more educationally sound, there is a rapid growth in the number of hospital schools. The curriculum offered in most programs is similar but there are areas of disagreement in regard to courses that should be added as well as procedures and clinical experience appropriate for this level of nursing. Confusion is also apparent in the remarks of the teachers who do not agree on the role to be filled by the nursing auxiliary.

This survey suggests the need for a study of nursing and a definition of the role of the auxiliary. This would provide a guide for cooperative planning of a more widely acceptable curriculum. Further studies should also be done in the area of teaching and clinical experience to determine the most satisfactory learning experiences.

There is no shortage of suitable applicants for auxiliary schools. Since students receive subsidies during their course and are readily employed afterwards, it is likely that the number of graduates will continue to spiral each year. It is thus urgent that action be taken to include this group in future plans for Canadian nursing. If this is not done soon they will make their own place.

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About Books

Right and Reason by Austin Fagothey, S.J. 511 pages. The C. V. Mosby Co., St. Louis. Ed. 3, 1963.
Reviewed by Miss Viola M. Aboud, Montreal General Hospital, Montreal, Quebec.

This is a study of ethics approached from a new starting point — that of modern value theory — but the conclusions derived are still those of the Aristotelian-Thomistic synthesis. Ethics is defined as "the practical normative study of the rightness and wrongness of human conduct as known by natural reason."

The problem method is used in each chapter to introduce one of the major questions in ethics; to explain how it arose and why it is a problem; to give the main schools of thought on the subject; to state the arguments for and against each proposed solution; to weigh the arguments against one another and finally to resolve the problem, if it can be resolved, in the light of the evidence and reasoning involved. The use of ordinary and current language rather than a technical and latinized vocabulary; the inclusion of short summaries at the end of each chapter; the presence of reading lists make this book easy to read. It is comprehensive in scope and stimulates the reader to seek other sources for further information on the various subjects discussed.

It would be useful as a general reference on ethics and of value in any library.

Medical Terminology: A Programmed Text by Genevieve L. Smith and Dean Phyllis E. Davis, John Wiley & Sons, Inc., 605 Third Avenue, New York 16, N.Y.

This text is intended for students planning careers in the fields of medicine, nursing and other paramedical professions. Its aim is to teach the student medical terminology.

Although the text can be used by the student without assistance, the authors recommend that for maximum effectiveness, it be used in a course that meets regularly with an instructor.

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Registered Nurses for 50-bed Auxiliary Hospital at Westlock, 50-mi. north of Edmonton, Alberta. Salary in accordance with AARN, experience recognized, 40-hr. wk., 3-wk. annual vacation. Applications to: Mrs. S. Marie, Matron, Auxiliary Hospital, Westlock, Alberta. 1-95-2

Registered Nurses for General Duty in active 21-bed hospital. Salary $315 to $360 per month depending on years of experience. M.S.I. and pension plan. 21 days vacation per year plus nine statutory holidays. For further particulars apply to: Director of Nursing, Berwyn Municipal Hospital, Berwyn, Alberta. 1-8-1

Registered Nurses for General Duty (O.R. training helpful). Starting salary $330 annual increments to $360, board and room $30/m, Group medical insurance and pension plans available. Please do not apply unless prepared to accept position. Apply to: The Matron, General Hospital, Bow Island, Alberta. 1-11-2

Registered Nurses (2) for General Duty Nursing. — Immediate vacancies — New personnel policies, according to AARN recommendations. Minimum salary $330, allowance made for previous experience. Apply: Director of Nursing, Municipal Hospital, Mayerthorpe, Alberta. 1-61-1

General Duty Nurses for modern 60-bed fully accredited hospital situated 70 mi. northwest of Edmonton. Good personnel policies. Residence accommodation. For further particulars apply to: Administrator, St. Joseph's Hospital, Barrhead, Alberta. 1-3-1

General Duty Nurses for well-equipped 76-bed hospital in active town of 3,000. Salary $315-$360 for Alberta registered; $305-$350 for non-Alberta registered. New separate residence, excellent personnel policies and working conditions. Apply to: Director of Nursing, Brooks General Hospital, Brooks, Alberta. 1-13-1

General Duty Nurses. Starting salary: $315 per mo., 40 hr. work wk. Room, board & laundry available, if desired, at nominal rates. Civil Service holiday, sick leave & pension benefits. Apply to: Baker Memorial Sanatorium, Dept. of Public Health, Calgary, Alberta. 1-14-3

General Duty Nurses (2) for modern 25-bed hospital on Highway No. 12. Salary range $340 to $385. New staff residence. Full maintenance $35, personnel policies include Blue Cross, M.S.I. and pension plans. 21 days' vacation per year, plus statutory holidays. Apply to the: Director of Nurses, Municipal Hospital, Coronation, Alberta. 1-25-1

General Duty Nurse for active 27-bed hospital. Modern industrial town 16 miles from Jasper Park on Main-line C.N.R. Interest in operating room an asset. Salary as per AARN recommendation. Full board in modern residence $35. monthly. Apply: Director of Nursing, Hinton Municipal Hospital, Hinton, Alberta. 1-47-1A

General Duty Nurses (2 immediately) for modern 35-bed hospital on Highway 2, 20 miles South of Edmonton. Basic salary $315. with three annual increments. New Staff residence. Full maintenance $35., personnel policies include Blue Cross, M.S.I. 21 days' vacation per year, plus statutory holidays. Apply to: Director of Nurses, Municipal Hospital, Leduc, Alberta. 1-56-1

General Duty Nurses (2) for 34-bed General Hospital. Salary $315-$360/m commencing at $330 with 1 year practical experience. Full maintenance at $35/m. Train fare from any point in Canada will be refunded after 1 year employment. Apply to: Municipal Hospital, Two Hills, Alberta. Phone 335. 1-88-1

Graduate Nurses. Salary: $315 to $360/m. 5 day, 40-hr. wk., 31 days paid vacation after 12 mo. continuous employment, also generous sick time and pension benefits. For further particulars please apply to: M. Hawkes, R.N., Superintendent of Nurses, Municipal Hospital, Drumheller, Alberta. 1-31-2

GRADUATE NURSES for General Duty, differential for advanced preparation in Psychiatric Nursing. Salary $315 - $375/m, 40-hr. wk., Civil Service holiday, sick leave and pension benefits, good personnel policies. This is an active treatment Mental Hospital conducting an approved School of Nursing, 60 miles from Edmonton. Apply to: Director of Nursing, Provincial Mental Hospital, Ponoka, Alberta, giving full particulars. 1-72-2

Public Health Nurses for main office in City of Grande Prairie. Car provided. Salary $4,320 allowing for previous experience. Without Public Health qualifications $3,780. Applications to: Dr. R. T. Pagan, Grande Prairie Health Unit, Grande Prairie, Alberta. 1-42-3

NURSES fully qualified for 30-bed active treatment hospital. New hospital building and recently renovated nurses' residence. Unless definitely interested in coming, please do not apply. Personnel policies sent upon request. Apply to: Mrs. M. Hislop, Superintendent, General Hospital, Bassano, Alberta. 1-5-1

NURSES required for combined public health and minor treatment services for two northern Alberta communities. Starting salary in relation to training and experience. Holiday, sick leave and pension benefits in accordance with Provincial Public Service regulations. Good accommodation and utilities provided. Apply to: Director of Public Health Nursing, Department of Public Health, Administration Building, Edmonton, Alberta. 1-33-16

BRITISH COLUMBIA

Director of Nursing for active, modern 54-bed hospital in Central B.C. Expansion of services planned. RNABC policies in effect. Salary commensurate with experience and qualifications. Apply, stating experience, qualifications, salary expected and availability to: Administrator, Mills Memorial Hospital, Terrace, British Columbia. 2-70-2A

Surgery Charge Nurse for modern accredited 100-bed hospital. Postgraduate or surgery experience preferred. RNABC schedule range $366 - $445 plus p.g. or experience differentials. Department of five. Write: Director of Nursing, Kootenay Lake General Hospital, Nelson, British Columbia. 2-47-1

Supervisor for very active Obstetrical Department. Basic salary $384 plus increments for experience and training. Post-basic course required and advanced training preferred. Apply to: Director of Nursing, Prince George Regional Hospital, Prince George, British Columbia. 2-57-1

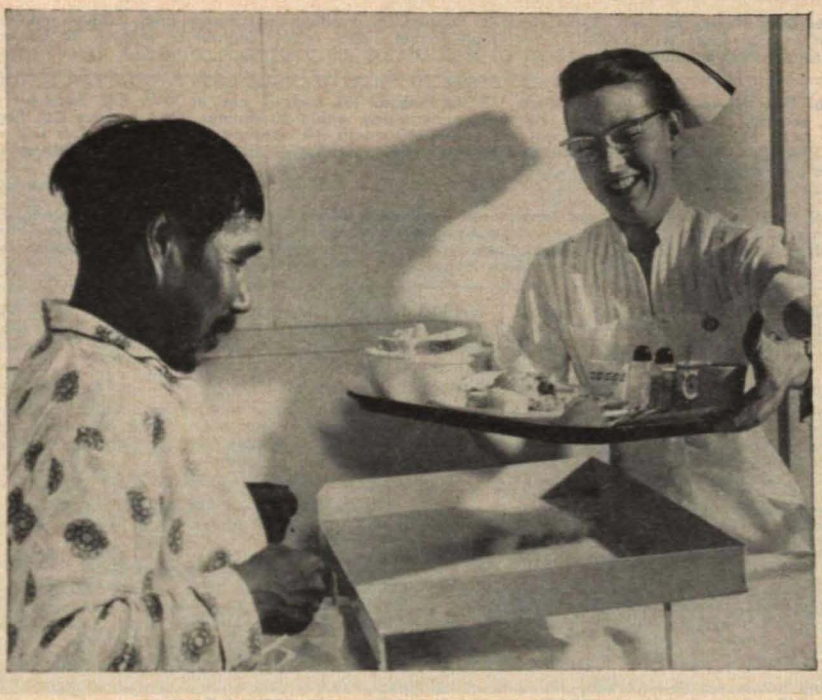
Operating Room Head Nurse (Experienced) with postgraduate course for modern accredited 82-bed hospital. Salary: $381-$460 according to experience plus RNABC allowance for postgraduate course. Accommodation available, 10 statutory holidays, 4-wk. vacation, superannuation and medical plan coverage. Apply: Director of Nursing, General Hospital, Kitimat, British Columbia. 2-36-1A

Registered or Graduate Nurses (3) for 15-bed hospital, situated on the beautiful Arrow Lakes, B.C. Standard B.C. salaries,, holidays, 40-hr. wk., living in accommodations at low cost. Apply to: Administrator, Arrow Lakes Hospital, P.O. Box 87, Nakusp, British Columbia. 2-45-1

Registered or Graduate General Duty Nurses for active 25-bed hospital. Salary B.C. registered $320 to start; unregistered $305. RNABC personnel policies in effect, nurses' residence available. Apply: Administrator, Lady Minto Hospital, Ashcroft, British Columbia. 2-4-1

NURSING WITH

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PUBLIC HEALTH NURSES
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Those interested in positions at the following locations should write to: Fisher River Hospital, HODGSON, MAN.; Miller Bay Hospital, PRINCE RUPERT, B.C.; Moose Factory Hospital, MOOSE FACTORY, ONT.; Norway House Hospital, NORWAY HOUSE, MAN.; Sioux Lookout Indian Hospital, SIOUX LOOKOUT, ONT.; Nanaimo Indian Hospital, NANAIMO, B.C.

Information on these and other positions is available from Medical Services Directorate, Department of National Health and Welfare, in Vancouver, Edmonton, Regina, Winnipeg, Ottawa and Quebec, or from the

DIRECTOR, PERSONNEL SERVICES

DEPARTMENT OF NATIONAL HEALTH AND WELFARE, OTTAWA

Registered Nurses or Graduate Nurses for 75-bed hospital opened in September 1962. Salary B.C. registered nurse $332-$404; salary non-registered nurse $317, RNABC policies in effect. Very active town in Cariboo Ranching country. Apply: Director of Nursing, Cariboo Memorial Hospital, Williams Lake, British Columbia. 2-80-1

General Duty Nurses (2) for 30-bed active hospital (Accredited). RNABC policies in effect. Apply: Director of Nursing, Creston Valley Hospital, Creston, British Columbia. 2-16-1

General Duty Nurses for active 30-bed hospital. RNABC policies and schedules in effect, also Northern allowance. Accommodations available in residence. Apply: Director of Nursing, General Hospital, Fort Nelson, British Columbia. 2-23-1

General Duty Nurses for new 30-bed hospital located in excellent recreational area. Salary and personnel policies in accordance with RNABC. Comfortable Nurses' home. Apply: Director of Nursing, Boundary Hospital, Grand Forks, British Columbia. 2-27-2

General Duty Nurses for fully accredited 113-bed hospital (82 beds in use) in N.W. B.C. Excellent fishing, skiing, skating, curling and bowling. Hot springs swimming within 20 minutes. 1964 salaries B.C. Registered $347 - $419. Non-Registered $332. Room and board $50/month. 10 statutory holidays, 1½ days sick leave, 4 weeks vacation. Superannuation and Medical Plan coverage. Apply: Director of Nursing, Kitimat General Hospital, Kitimat, British Columbia. 2-36-1

General Duty, Operating Room and Experienced Obstetrical Nurses for 434-bed hospital with school of nursing. Salary: $332-$404. Credit for past experience and postgraduate training. 40-hr. wk. Statutory holidays. Annual increments; cumulative sick leave; pension plan; 28-days annual vacation; B.C. registration required. Apply: Director of Nursing, Royal Columbian Hospital, New Westminster, British Columbia. 2-73-13

General Duty Nurses for 110-bed hospital in northwestern B.C. Salary—B.C. registered $347-$419; non-registered $332. Newly furnished residence with T.V. Good social activities, including bowling, curling, tennis and year-round swimming. Full personnel benefits including travel allowance. Apply to: Director of Nursing, General Hospital, Prince Rupert, British Columbia. 2-58-2

General Duty Nurses for well-equipped 80-bed General Hospital in beautiful inland valley adjacent Lake Kathlyn and Hudson Bay Glacier. Initial salary $347, maintenance $60, 40-hr. 5-day wk., 4-wk. vacation, Boating, fishing, swimming, golfing, curling, skating, skiing. Comfortable nurses' residence, rail fare advanced if necessary. Apply: Sacred Heart Hospital, Smithers, British Columbia. 2-73-13

Graduate Nurses for 60-bed modern hospital in resort area on Vancouver Island. R.N. basic rate $332/m with yearly increments according to RNABC personnel policies. Enquiries: Director of Nursing, Campbell River & District General Hospital, Campbell River, British Columbia. 2-9-1

Graduate Nurses and Certified Nursing Assistants for 70-bed acute General Hospital on Pacific Coast. Salary for Graduates in accordance with RNABC scale with credit for experience; Nursing Assistants $220-$253 Board and room $25/m; 4-wk. vacation after 1-yr. Superannuation and medical plans. Apply: Director of Nursing, St. George's Hospital, Alert Bay, British Columbia. 2-2-1

Graduate Nurses for General Duty, in medicine, surgery, obstetrics, pediatrics and operating room in new, modern 188-bed hospital in city (20,000) on east coast of Vancouver Island. Personnel policies in accordance with RNABC policies. Starting salary for R.N. — $332 approx./m. Apply to: Director of Nursing, Regional General Hospital, Nanaimo, British Columbia. 2-46-1

Operating Room, Obs. and General Duty Nurses for modern 450-bed hospital with a school of nursing RNABC policies in effect. Salary $332/m. Credit for past experience and postgraduate training. 40-hr. wk., 10 statutory holidays, Annual increments, cumulative sick leave, pension plan, 28-day annual vacation. B.C. registration required. For particulars write to: Director of Nursing Service, St. Joseph's Hospital, Victoria, Vancouver Island, British Columbia. 2-76-5

Two Nurses WANTED for Christian service in a mission hospital of the United Church in Northern B.C. Apply: Wrinch Memorial Hospital, Hazelton, British Columbia. 2-29-1

DO IT NOW! WHY WAIT FOR SPRING FOR THAT CHANGE? Graduate Nurses will be needed to increase the staff of the new 81-bed acute General Hospital, 30 miles from Vancouver, B.C. Applications will be received now for the opening in January, 1965 of the new Langley Memorial Hospital. Apply to: The Director of Nursing, Murrayville, British Columbia. 2-44-1

ENGLAND

NEUFIELD ORTHOPEDIC CENTRE, HEADINGTON, OXFORD, ENGLAND. Applications are invited from State Registered Nurses wishing to take the year's Postgraduate Course for the Orthopedic Nursing Certificate. Staff Nurses salary is paid during the course which includes five weeks Study Block. Course commences in February, June and October. Apply to: The Matron. 14-1-14

MANITOBA

REGISTERED NURSE for Medical Clinic. Good salary with increments, pleasant working conditions. Applications with details of qualifications, experience, and personal data to: Hanover Medical Clinic, Box 640, Steinbach, Manitoba. 3-59-2

Registered General Duty Nurses (2). Immediately, for fully modern 20-bed hospital. Salary: $330/m. 40 hr. wk. Increments of $5.00 every 6 mo. for 8 increments. Full maintenance available at the hospital for $45/m. For further information and application form apply to: Mrs. Olive Campbell, Matron, Hunter Memorial Hospital, Teulon, Manitoba. 3-63-1

FOOTHILLS PROVINCIAL GENERAL HOSPITAL

Calgary, Alberta

This 766-bed general hospital now under construction adjacent to the University of Alberta, Calgary, is scheduled to open in April, 1966. The School of Nursing is scheduled to open in September, 1965.



SENIOR NURSING POSITIONS

The administration is interested in soliciting applications now from persons qualified by preparation and experience to assume senior nursing positions.

NURSING EDUCATION — Appointment of classroom/clinical instructors will commence May, 1965.

NURSING SERVICE — Appointment of supervisors in general and special areas over the twenty-four hours will commence September, 1965.

Applications are also invited for the positions of:

SUPERVISOR OF CENTRAL SUPPLY
SUPERVISOR OF OPERATING ROOMS
SUPERVISOR OF NURSING ORDERLIES

Further information and application forms may be obtained by writing to:

THE DIRECTOR OF NURSING, FOOTHILLS HOSPITAL,
POSTAL STATION "B", CALGARY, ALBERTA.

Registered Nurses (2) and L.P.N.'s (2) for 32-bed fully modern hospital in the lovely Parkland of North-West Manitoba. Two buses daily to Yorkton and Winnipeg. Salary $320 and $225 respectively with additional monetary consideration allowed for experience. A 40-hr. wk. is in effect, 3-wk. vacation after one year employment, life insurance and pension plan in effect. Personnel policies supplied on request. For further information write or phone 180 collect, to: Mrs. Edna Sims, Superintendent, Roblin District Hospital, No. 2, Roblin, Manitoba. 3-48-1

Registered and Practical Nurses (immediately) for 18-bed hospital at Vita, Man., 70-mi. from Winnipeg. Starting salary, R.N. $330 - L.P.N. $225, with allowance for experience. Daily bus service. 40-hr. wk., full maintenance available for $50/m. Apply to: Matron, District Hospital, Vita, Manitoba. 3-68-1

General Duty Registered Nurses for 62-bed general hospital situated in progressive community with good recreational facilities and residence accommodation. Salary range $310 - $360. Allowance for experience. 40-hr. wk. with usual vacation, sick leave and other benefits. For further information contact: Mrs. E. R. Baudin, Director of Nurses, Swan River Hospital, Swan River, Manitoba. 3-62-2

General Duty and Licensed Practical Nurses for 100-bed active treatment hospital with newly opened 35 bed extended treatment wing. 40 hour work week, excellent personnel policies, residence facilities. Situated in the parkland, just a few miles from Clear Lake summer resort and Agassiz ski resort. Apply to: Mrs. M. Paul, R.N., Director of Nursing, General Hospital, Dauphin, Manitoba. 3-17-1

Licensed Practical Nurse for The Glenboro Hospital, Glenboro, Manitoba. Duties to commence as soon as possible. Salary range $225 - $265 monthly. Residence accommodation available in fully modern residence. Glenboro is located on No. 2 Highway 45 miles east of Brandon, 100 miles west of Winnipeg. Excellent social, religious and sporting facilities are available. Personnel Policy Manual and application forms mailed on request with no obligation. Please contact Mr. S. A. Oleson, Box No. 130, Glenboro, Manitoba. 3-28-1

NOVA SCOTIA

Registered Nurses for 21-bed hospital in pleansant community — Eastern Shore of Nova Scotia. Apply: Superintendent, Eastern Shore Memorial Hospital, Sheet Harbour, Nova Scotia. 6-32-1

General Duty Nurses for modern 35-bed hospital situated on beautiful South Shore. Good personnel policies. Excellent living quarters. Apply: Superintendent, Fishermen's Memorial Hospital, Lunenburg, Nova Scotia. 6-21-1

ONTARIO

Director of Nurses for well-equipped 42-bed General Hospital located in heart of area known for its wealth of natural resources. The sportsminded person has unlimited activities to enjoy. Residence suite available. For further information please phone or write: The Administrator, Sioux Lookout General Hospital, P.O. Box 909, Sioux Lookout, Ontario. 7-119-1A

SUPERVISOR OF IN-SERVICE EDUCATION (Immediately) Responsible for orientation of staff and continuing education to equip employees for growing responsibilities and new positions. Preference will be given to an applicant with university preparation supported by practical experience in a General Hospital. Attractive personnel policies, pension plan and allowance for experience. Apply in writing to: Director of Nursing, The Wellesley Hospital, 160 Wellesley Street East, Toronto 5, Ontario. 7-133-49B

Assistant Operating Room Supervisor for active area; salary in accordance with educational preparation and experience; apply to: Director of Nursing, The Doctors Hospital, 45 Brunswick Avenue, Toronto 4, Ontario. 7-133-9A

Obstetrical Nursing Supervisor for 325-bed, fully accredited, General Hospital located in central area of city; salary in accordance with educational preparation and experience; apply to: Director of Nursing, The Doctors Hospital, 45 Brunswick Avenue, Toronto 4, Ontario. 7-139-9B

INSTRUCTORS (Immediately) for Clinical and Classroom Teaching in a progressive school program emphasizing educational experiences for the student. Requirements: University preparation in Nursing Education. Allowance given for experience. Apply in writing to: Director of Nursing, The Wellesley Hospital, 160 Wellesley Street East, Toronto 5, Ontario. 7-133-49A

Head Nurse — (Pediatrics) for 30-bed modern unit; hospital located in central area of city; salary in accordance with educational preparation and experience; apply to: Director of Nursing, The Doctors Hospital, 45 Brunswick Avenue, Toronto 4, Ontario. 7-139-9C

Registered Nurses for modern 166-bed General Hospital. Interesting general duty positions open in all areas. Starting salary (1964): $330/m., 37½-hr. work wk. Congenial atmosphere, excellent fringe benefits and personnel policies. Limited residence accommodation available. For further particulars write: Director of Nursing, Memorial Hospital, Bowmanville, Ontario. 7-14-1

Registered Nurses for new 65-bed hospital. Resort area. Salary range: $315/m. Up-to-date personnel policies. Apply: Director of Nurses, South Muskoka Memorial Hospital, Bracebridge, Ontario. 7-15-1

Registered Nurses for Surgical, Medical, Pediatric, Obstetrical, Departments and Operating Room, required by 100-bed General Hospital, situated in Northern Ontario. Starting salary $360, annual increments, good personnel policies, including 40 hours per week. O.H.A. pension plan and group life insurance, O.H.S.C. and P.S.I. plans in effect. Accommodation available in residence if desired. For further particulars apply to: Director of Nurses, Lady Minto Hospital, Cochrane, Ontario. 7-30-1

Registered Nurses for 34-bed hospital, min. salary $350/m. — max. of $450 in five years, 3-wk. vacation with pay, sick leave after 6-mo. service. **All Staff** — 5 day 40-hr. wk., 9 statutory holidays, pension plan & other benefits. Apply to: Superintendent, Englehart & District Hospital, Englehart, Ontario. 7-40-1

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Fashion your career in nursing in any field you might desire—the choice is yours. At "Cook County", opportunity unlimited awaits you. Increase your knowledge and experience, pursue your special area of interest, grow with your profession. Here you feel the pulse-beat of nursing, its importance and the vital role it plays in the world of today. You make a wise decision when you join the staff of Cook County Hospital . . . it is, indeed, a solid foundation on which to build your future.

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$475.00/Mo.

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Registered Nurses. Applications and enquiries are invited for general duty positions on the staff of the Manitouwadge General Hospital. Excellent salary and fringe benefits. Liberal policies regarding accommodation and vacation. Modern well-equipped 33-bed hospital in new mining town, about 250-mi. east of Port Arthur and north-west of White River, Ontario. Pop. 3,500. Nurses' residence comprises individual self-contained apts. Apply, stating qualifications, experience, age, marital status, phone number etc. to the Administrator, General Hospital, Manitouwadge, Ontario. Phone 826-3251. 7-74-1A

Registered Nurses for 25-bed hospital. Minimum salary: $350 with allowance for experience. Registered Nursing Assistants, minimum salary: $250 with allowance for experience. Excellent fringe benefits. Board and room available in residence: $45/m. Apply to: Mrs. G. Gordon, Superintendent, Nipigon District Memorial Hospital, 98 Churchill St., Nipigon, Ontario. 7-87-1

Registered Nurses and Registered Nursing Assistants for well equipped 75-bed hospital in progressive town of 6,500, situated midway between Winnipeg and the Canadian Lakehead. Basic wage Reg.N., $330 and Reg.N.Ass'ts, $230/m with single room accommodation available in modern nurses' residence. Excellent personnel policies. For further information, please phone or write: The Director of Nursing, Dryden District General Hospital, Dryden, Ontario. 7-36-1

Registered Nurses, Certified Nursing Assistants (IMMEDIATELY) for 40-bed hospital in pleasant town of 5,000. 42-hr. wk. with good rotation shifts, providing long weekends every 4 wks. Good salaries and personnel policies. For further details and application, apply: Administrator, General Hospital, Espanola, Ontario. 7-41-1

Registered Nurses and Certified Nursing Assistants for 160-bed accredited hospital. Starting salary $350 and $240 respectively with regular annual increments for both. Excellent personnel policies. Residence accommodation available. Apply to: Director of Nursing, Kirkland & District Hospital, Kirkland Lake, Ontario. 7-67-1

Registered Nurses and Certified Nursing Assistants for immediate and future vacancies in this 42-bed hospital. Starting salaries $335 and $225, respectively. Accommodation in new residence available. Usual fringe benefits. For full information, apply to: Director of Nursing, New Liskeard and District Hospital, New Liskeard, Ontario. 7-83-1

Registered Nursing Assistants for well-equipped 42-bed General Hospital located in area known for its wealth of natural resources. The sportsminded person has unlimited activities to enjoy. Starting salary: $230/m. Excellent personnel policies. Accommodation available in well-furnished nurses' residence. For further information, please phone or write: The Director of Nursing, Sioux Lookout General Hospital, P.Q. Box 909, Sioux Lookout, Ontario. 7-119-1

Registered Nurses for General Duty in well-equipped 28-bed hospital, located in growing gold mining and tourist area, north of Kenora, Ontario. Modern residence with individual rooms; room, board and uniform laundry only $45. 40-hr. wk., no split shift, cumulative sick time, 8 statutory holidays and 28 day paid vacation after one year. Salary range $350 - $375. Apply to: Matron, Margaret Cochenour Memorial Hospital, Cochenour, Ontario. 7-29-1

Registered Nurses for General Duty in modern 100-bed hospital in northern area. Residence accommodation. Starting salary $350. Recognition for experience. Personnel policies include: 40-hr. week, 8 statutory holidays, 3-wk. vacation, pension plan. Life insurance, medical insurance. Apply: Administrator, St. Joseph's General Hospital, Elliot Lake, Ontario. 7-39-1

Registered Nurses for General Duty in small sized General Hospital located 30-mi. from Ottawa. Good personnel policies. Apply: Superintendent, District Hospital, Kemptville, Ontario. 7-63-1

Registered Nurses for General Duty in all departments including premature and new-born nursery, isolation, Emergency, Recovery Room, and Intensive Care Unit. Good salary and personnel policies. Apply: Director of Nursing, Victoria Hospital, London, Ontario. 7-73-10

Registered Nurses for General Duty in modern 40-bed hospital. Starting salary $325, gross, monthly. 40-hr. wk., 10 working days sick leave in one year, 50% unused sick leave paid at end of year. 50% single OHSC, PSI and Group Life Insurance premiums given also OHA Pension Plan available, 8 statutory holidays, 4-wk. vacation after one year. Board and room $30. Apply: Superintendent, Saugeen Memorial Hospital, Southampton, Ont. 7-122-1

Registered Nurses for Operating Room (3) required immediately for 100-bed fully accredited hospital in the planning stage of expansion to 200 beds. Starting salary $325/m, annual increments, good personnel policies, including 40 hour week, pension plan and group life insurance, O.H.S.C. and P.S.I. plans in effect. For further particulars apply to: Director of Nurses, Civic Hospital, North Bay, Ontario. 7-88-1

Registered Nurses for General Duty & Operating Room in modern hospital (opened in 1956). Situated in the Nickel Capital of the world, pop. 80,000 people. **Salary: $335 per mo.,** with annual merit increments, plus **annual bonus plan,** 40-hr. wk. Recognition for experience. Good personnel policies. Assistance with transportation can be arranged. Apply: Director of Nursing, Memorial Hospital, **Sudbury,** Ontario. 7-127-4

Registered or Graduate Nurses for modern 100-bed hospital located in summer resort district, 40-mi. from Ottawa. Apply: Director of Nursing, Public Hospital, Smiths Falls, Ontario. 7-120-2

General Duty Nurses for 66-bed General Hospital. Starting salary: $335/m. Excellent personnel policies. pension plan, life insurance, etc., residence accommodation. Only 10 min. from downtown Buffalo. Apply: Director of Nursing, Douglas Memorial Hospital, Fort Erie, Ontario. 7-45-1

General Duty Nurses for modern 100-bed hospital. Registered Nurses $325-$355/m, Graduates $285-$325/m, 40-hr. wk., benefits include accident, sickness and life insurance, hospital and medical insurance plans, & OHA Pension Plan. Apply: Miss Tillett, Director of Nursing, Leamington District Memorial Hospital, Leamington, Ontario. 7-69-1

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Our personnel work a 40-hour work week with **NO** rotation of shifts, split days or split time, and receive a bonus of $100 per month for the 3-11 shift and $50 per month for the 11-7 shift.

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Baltimore is within easy traveling distance of Washington, D.C. and other major cities of the eastern seaboard. Baltimore offers well-known cultural, recreational, and educational resources, including symphonies, operas, theatre and sports. Concert, theatre and indoor sports are presented at the new Civic Center. Water sports are available on the famous Chesapeake Bay. Professional football and baseball are presented at Memorial Stadium. Five universities present the opportunity for further educational and professional development.

Starting salary range is $4,221.60 - $4,616.76 depending upon experience and educational qualifications, with a merit increase program and opportunities for advancement.

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General Duty Nurses for 100-bed modern hospital, southwestern Ontario, 32 mi. from London. Salary commensurate with experience & ability; $325/m basic salary. Pension plan. Apply giving full particulars to: The Director of Nurses, District Memorial Hospital, Tillsonburg, Ontario. 7-131-1

General Duty Nurses for 325-bed fully accredited General Hospital located in downtown area of city. Planned orientation program. Progressive personnel policies. Apply to: The Director of Nursing, The Doctors Hospital, 45 Brunswick Avenue, Toronto 4, Ontario. 7-133-9

General Duty Nurses & Certified Nursing Assistants for new 50-bed hospital with modern equipment, 40-hr. wk., 8 statutory holidays, excellent personnel policies & opportunity for advancement. Tourist town on Georgian Bay. Good bus connections to Toronto. Apply to: Director of Nurses, General Hospital, Meaford, Ontario. 7-79-1

Graduate Nurses for 55-bed General Hospital located in Picton, Ontario. Positions open in all Departments. For information regarding salary and personnel policies, please write: Director of Nursing, Prince Edward County Memorial Hospital, PICTON, Ontario. 7-104-1

Graduate Nurses and Certified Nursing Assistants (Immediately) for progressive rapidly expanding hospital in central Toronto. Salary commensurate with experience and excellent employee benefits. For specific information please reply in confidence to: The Director of Nursing, The Wellesley Hospital, 160 Wellesley Street East, Toronto 5, Ontario. 7-133-49

Operating Room Nurse for small-sized hospital 30 miles from Ottawa. Good personnel policies. Apply: Superintendent, Kemptville District Hospital, Kemptville ,Ontario. 7-63-1A

Operating Room Nurses for general operating room work which includes cardiovascular, neurosurgery, genito-urinary, ear, eye, nose and throat and orthopedic surgery. Good salary and personnel policies. Apply: Director of Nursing, Victoria Hospital, London, Ontario. 7-73-10A

Operating Room Nurses (2) and General Duty Nurses for this 150-bed hospital. Salary scales as applicable in Ontario. Recognition for experience. All conventional benefits available. Apply giving details of training and experience to: The Director of Nursing, The Cottage Hospital, Pembroke, Ontario. 7-98-1

Public Health Nurse for generalized program in an urban-rural Health Unit, adjacent to Metropolitan Toronto. Salary range $4,000 to $5,200. Good personnel policies. Apply to: Supervisor of Nursing, Peel County Health Unit, 16 Lynch Street, Brampton, Ontario. 7-16-3

Public Health Nurses (Qualified) for generalized program, by Stormont, Dundas and Glengary Health Unit located in the Seaway Valley area. Minimum salary $4,000. Annual increments. Allowance for experience 5-day wk. Employer-shared (50-50) group insurance, portable OMERS pension plan, Ontario Hospital Insurance and P.S.I. coverage (medical, surgical and obstetrical plan). 3-wk. vacation, cumulative sick leave credits, one-half paid as bonus upon leaving after 3-yr. service. Generous car allowance. Reply in writing to: Dr. John A. Thomson, Medical Officer of Health, Box 1058, Cornwall, Ontario. 7-34-5

PUBLIC HEALTH NURSE (QUALIFIED). Salary range $4,200 - $5,200; annual increment $210. Required in a generalized program in the City of Oshawa. Transportation provided and usual employee benefits. Apply to: D. Fleming, Personnel Officer, Civic Administration Bldg., OSHAWA, Ontario. 7-92-2

Public Health Nurses for a generalized program. Minimum salary $4,000 with allowance for experience. Additional benefits include, OMERS pension plan, 50% of Hospital Insurance and Physicians' Services Blue Plan, cumulative sick leave, 4-wk. vacation, generous travel allowance. Apply to: Dr. F. R. Manuel, Medical Officer of Health, Grey County Health Unit, County Building, Owen Sound, Ontario. 7-94-3

Public Health Nurses, (qualified), for Oxford Health Unit, Generalized program. Good personnel policies. Salary range and personnel policies on request. Apply to: Supervisor of Public Health Nursing, Oxford Health Unit, Woodstock, Ontario. 7-147-4

STAFF NURSES FOR 220-BED ACCREDITED HOSPITAL with School of Nursing. Salary $325. Preference for any particular service given every consideration. Post-Basic Certificates recognized. Usual personnel benefits, plus proximity to Ottawa, Montreal and Northern New York State. Apply: Assistant Director of Nursing (Service), General Hospital, Cornwall, Ontario. 7-34-1

BERMUDA

Registered Nurses for General Staff. Salary commences at £55-0-0 per mo. Full maintenance in new residence. Transportation allowance. For full particulars, apply: Matron, King Edward VII Memorial Hospital, Bermuda. 13-1-1A

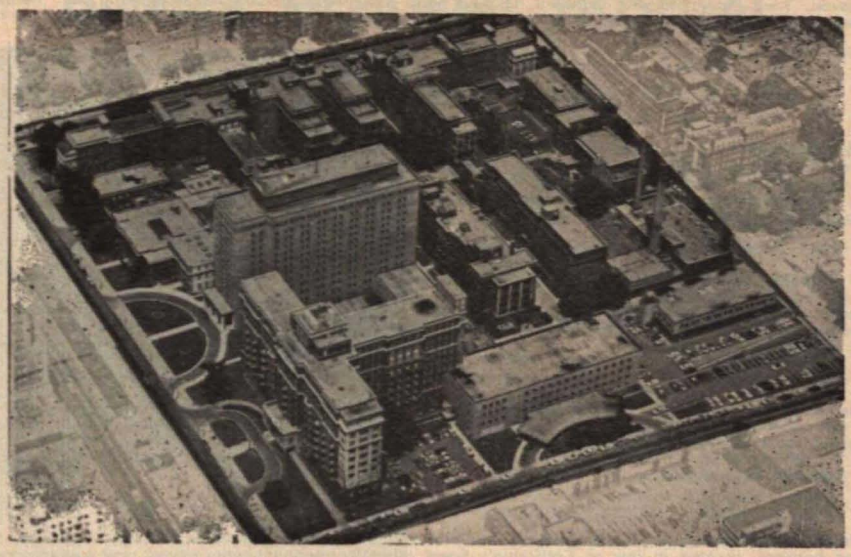
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Assistant Head Nurses and Certified Nursing Assistants for 60-bed children's orthopedic hospital. Excellent personnel policies. Apply: Miss Flora M. Lamont, Reg.N., Administrator, Shriners Hospital for Crippled Children, 1529 Cedar Avenue, Montreal 25, Quebec. 9-47-42

Registered Nurses for 30-bed General Hospital, 50 mi. from Centre of Montreal. Excellent bus service. Starting salary: $325/m. Salary increases as recommended by ANPQ. 40-hr. wk. Annual vacation, statutory holidays, 2-wk. sick leave, Blue Cross paid, living accommodation available. Apply: Mrs. D. Hawley, R.N., County Hospital, Huntingdon, Que. 9-29-1

Operating Room Nurses for 56-bed accredited General Hospital, 38 miles from Montreal. Salary range $355-$385/m. Excellent working conditions, 5 day week, 4 weeks vacation after one year's service. Living accommodation available in modern motel type residence complete with out-door swimming pool. Apply to: Mrs. M. Fearn, Director of Nursing, Barrie Memorial Hospital, Ormstown, Quebec. 9-52-18

TORONTO GENERAL HOSPITAL



NURSING OPPORTUNITIES

for

REGISTERED NURSES AND REGISTERED NURSING ASSISTANTS

Planned Orientation Programme — Inservice Educational Programmes
Opportunity to gain additional knowledge in specialized fields of nursing
Excellent personnel policies
Salaries commensurate with prevailing current salaries in Metropolitan Toronto

For information or application write to:

DIRECTOR OF NURSING, TORONTO GENERAL HOSPITAL,
101 College Street, Toronto 2, Ontario.

SUDBURY ALGOMA SANATORIUM

Requires for New Psychiatric Unit

SUPERVISOR: Postgraduate training and experience in Psychiatry essential. Diploma Course in Teaching and Supervision an asset.

REGISTERED NURSES: With postgraduate training and experience in Psychiatry, for general staff duty.

Salary for both positions commensurate with education and experience.

Apply to:

DIRECTOR OF NURSING,
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REGISTERED NURSES REQUIRED

FOR GENERAL DUTY IN MODERN 18-BED PRIVATE HOSPITAL IN IRON MINING TOWN
140 miles north of Sault Ste. Marie, Ontario
SALARY RANGE $330 MINIMUM TO $377 MAXIMUM
Allowance for experience. Board and room available at $20 per month
Transportation allowance up to $50 after 6 months

Apply:

SUPERINTENDENT OF NURSES, LADY DUNN HOSPITAL, WAWA, ONTARIO

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Graduate Nurses for 8-bed hospital in Southern Sask. Salary range $335 - $425. Qualifications and experience considered. 3-wk. vacation plus statutory holidays, and 40-hr. wk. Modern residence with T.V. Personnel policies on request. Apply to: Mrs. D. L. Knops, Sec.-Treas., Union Hospital, Rockglen, Saskatchewan. 10-110-1

U.S.A.

T.B. SUPERVISOR for two ward unit in General Hospital. Minimum 2 years' experience in T. B. nursing required. Eligible for California registration. Salary $481-$505/m. Living accommodation for single women at nominal charge; modern well-equipped hospital in rural area. 15 working days vacation annually, sick leave, retirement plan including Social Security. Apply: Director of Nurses, Tulare-Kings Counties Hospital, Springville, California. 15-5-45

HEAD NURSES and STAFF NURSES for Orthopedic and Intensive Care Services, for 218-bed accredited General Hospital. Eligible for California registration. Salary $436-$481/m. Living accommodation for single women at nominal charge; modern well-equipped hospital in rural area. 15 working days vacation annually, sick leave, retirement plan including Social Security. Apply: Director of Nurses, Tulare-Kings Counties Hospital, Springville, California. 15-5-45A

Registered Nurses for modern 374-bed General Hospital on the beautiful, warm Peninsula yet only 20-min. from the heart of cosmopolitan San Francisco. Openings in all nursing services including operating room, emergency room, and I.C.U. Excellent personnel policies, many extra benefits and opportunities for advancement. Telephone collect. OXford 7-4061 or write: Director of Personnel, Peninsula Hospital, 1783 El Camino Real, Burlingame, California. 15-5-20

Registered Nurses. Career satisfaction, interest and professional growth unlimited in modern, JCAH accredited 254-bed hospital. Located in one of California's finest areas, recreational, educational and cultural advantages are yours as well as wonderful year-round climate. If this combination is what you're looking for, contact us now! Staff Nurse entrance salary $395 with automatic increase to $455 per mo., supervisory positions at increased rate. Special area and liberal shift differentials paid. Excellent benefits including Blue Cross hospitalization and surgical coverage and liberal personnel policies. Professional staff appointments available in all clinical areas to those eligible for California licensure. Write today: Director of Nursing, Eden Hospital, 20103 Lake Chabot Road, Castro Valley, California. 15-5-12

Registered Nurses for private 278-bed hospital for men, women and children. Staff Nurse salaries from $400 - $465, differentials for evenings and nights. Opportunities in all clinical areas. Holidays, vacations, sick leave, life insurance and health insurance. California registration required. Applications and details furnished on request. Contact: Personnel Director, Children's Hospital, 3700 California Street, San Francisco 18, California. 15-5-4

Registered Nurses for 233-bed modern hospital. Positions available — All services, no shift rotation. Liberal benefits, advancement opportunities, educational opportunities in area, equal opportunity employer. Apply: Director of Nursing Service, Kaiser Foundation, San Francisco 15, California. 15-5-7

REGISTERED NURSES — General Duty for 84-bed JCAH hospital 1½ hours from San Francisco, 2 hours from Lake Tahoe. Starting salary $420/m. with differentials. Apply: Director of Nurses, Memorial Hospital, Woodland, California. 15-5-49B

Registered Nurses, Staff Nurses for permanent positions, various departments, days, eves., nights. Excellent starting salary, increments, benefits and working conditions in one of the largest and finest general hospitals in the West. For details write: Personnel Department, Queen of Angels Hospital, 2301 Bellevue Avenue, Los Angeles 26, California. 15-5-3G

Registered Nurses General Duty for 230-bed approved teaching hospital, resort city. Starting salary $395 per mo. plus $22.50 shift differential, provision for housing allowance. Apply: Director of Nursing, Cottage Hospital, Santa Barbara, California. 15-5-39

(a) **Operating Room Nurses** (experienced); basic salary $385 with good financial reimbursement for call. (b) **Obs. Nurses** $385 basic salary with $20 differential for 3-11 or 11-7 shifts. (c) **General Duty Nurses** $375 basic salary; $20 diffeerntial for 3-11 or 11-7 shifts. Apply: Director of Nurses, General Hospital, Eureka, California. 15-5-14

Staff Nurses for 300-bed County Hospital. Attractive personnel policies plus differential for specialties, afternoon and night duty. Opportunities for advanced education. Apply to: Director of Nursing Service, Kaiser Foundation Hospital, Oakland 11, California. 15-5-3C

Staff Duty positions (Nurses) in private 403-bed hospital. Liberal personnel policies and salary. Substantial differential for evening and night duty. Write: Personnel Director, Hospital of The Good Samaritan, 1212 Shatto Street, Los Angeles 17, California. 15-5-3B

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HOSPITAL —

Newly expanded 350-bed hospital. Progressive patient care concept.

SALARY —

General Staff Nurses registered in Ontario $335 - $400 per month. Registered Nursing Assistants $235 - $271 per month.

HOUSING —

Furnished apartments available at subsidized rates.

JOB SATISFACTION —

High quality patient care and friendly working environment, personnel recognition and professional development.

You are invited to enquire concerning employment opportunities to:

DIRECTOR OF NURSING, HUMBER MEMORIAL HOSPITAL,
200 Church Street, Weston, Ontario — Telephone 249-8111 (Toronto).

NURSES, REGISTERED

250-BED GENERAL ACUTE HOSPITAL IN SAN FRANCISCO, CALIFORNIA

Immediate positions, all shifts, for nurses in Operating Room, Intensive Care-Cardiac Unit, and general staff duty.

Qualified applicants guaranteed positions for visa purposes. Current starting salary $400 plus $40 evening and $24 night shift, and specialty differentials.

Health Insurance Plan, Life Insurance Policy, and Retirement Program — all hospital paid. Liberal holiday and vacation benefits. Affiliated with University of California Medical School with accredited medical residencies in Medicine, General Surgery, Neuro-Surgery, Orthopedics, and Plastic Surgery.

For further information, write to:

Miss Lois Jahn, Director of Nursing,
FRANKLIN HOSPITAL,
14th and Noe Streets, San Francisco, California.

INSTRUCTOR — STAFF NURSING

required for

DIVISION OF NURSING EDUCATION, MENTAL HEALTH SERVICES, ESSONDALE, B.C.

B.C. CIVIL SERVICE

Applicants must be Canadian citizens or British subjects and be registered, or eligible for registration in the Registered Nurses Association of British Columbia; must have a diploma in teaching, supervision or administration, or a degree in nursing acceptable to the nursing education standards in B.C.; preferably two years' experience in general nursing, psychiatric nursing or nursing education; competence in nursing and teaching skills; organizational ability; initiative; effective interpersonal relations and sound judgment. Salary particulars upon request.

For application forms apply IMMEDIATELY to:

THE PERSONNEL OFFICER, B.C. CIVIL SERVICE COMMISSION,
Valleyview Lodge, Essondale, B.C. — COMPETITION No. 64:200A.

DIRECTOR OF NURSING

For 45-bed fully accredited modern General Hospital. Progressive community and hospital well equipped. Salary commensurate with qualifications and experience. Suite available in residence.

Please address enquiries and applications to:

Administrator,
ANSON GENERAL HOSPITAL,
Iroquois Falls, Ontario.

U.S.A.

Nurses for new 75-bed General Hospital. Resort area. Ideal climate. On beautiful Pacific ocean. Apply to: Director of Nurses, South Coast Community Hospital, South Laguna, California. 15-5-50

General Duty Nurses for 72-bed hospital, Salary $425/m, fringe benefits, College town, mountainous portion of Colorado. Contact: Superintendent, Alamosa Community Hospital, Alamosa, Colorado. 15-6-1

REGISTERED NURSES: for 75-bed air conditioned hospital, growing community. Starting salary $330-$365/m, fringe benefits, vacation, sick leave, holidays, life insurance, hospitalization. 1 meal furnished. Write: Administrator, Hendry General Hospital, Clewiston, Florida. 15-10-1

General Duty Nurses — Present hospital 55-beds, with new 75-bed hospital to open April, 1, 1965. Located on lake Okeechobee near West Palm Beach. Liberal personnel policies, 40-hr. wk., bonus at end of first year. Minimum starting salary $380, with differential for evenings and nights. Apply: Director of Nursing Service Memorial Hospital, P.O. Box 928, Belle Glade, Florida. 15-10-3

REGISTERED NURSES: Excellent opportunity for advancement in atmosphere of medical excellence. Finely equipped, growing 200-bed suburban community hospital on Chicago's famed "North Shore" offers stimulating professional contacts within framework of personal attention. Completely air-conditioned, furnished cottages; two week paid vacation, liberal personnel policies. Starting salary from $410 to $430 days. Differential of $30 for nights or evenings. Contact: Donald L. Thompson, R.N., Director of Nursing, Highland Park Hospital, Highland Park, Illinois. 15-14-3

Registered Nurses for General Staff Duty in 70-bed hospital with warm, friendly atmosphere. Salary range from $84.50 to $91 per week with a $10 differential for evenings and nights. **Delivery Room nurse,** 3-11 shift, and an **Emergency Room nurse,** 3-11 shift, needed. Rooms available in Nurses' home. Pleasant attractive community in New England. Please apply to: Miss Jean Lawson, R.N., Director of Nurses, Glover Memorial Hospital, Needham 92, Massachusetts. 15-22-6

Staff Nurses 380-bed hosp. new 120-med.-surg. unit. Trans. pd. 1st class air to Albuq. and return within U.S. in exchange for 1-yr. emp. contract. Come to New Mexico "Land of Enchantment." Career opportunities, largest pvt. JCAH accredited hosp. in state; near U. of New Mexico, R.N. & B.S. pgm. Practical Nurse pgm. accredited state & NAPNE. Vacancies, Med.-Surg. & occasionally O.B., Peds., & O.R., salaries $350 per mo. even., night or O.R. with call; annual increases up to $410; days $340 per mo. with increases up to $400 Rotation from day duty is required only when no person desiring permanent P.M. or night tour is available. Liberal personnel policies include: optional Blue Cross, Discount Hosp. Services, pd. sick leave cumulative to 5 wks., annual physical exam., vacation 1 yr. — 2 wks., 5 yrs. — 3 wks., 10 yrs. — 4 wks. Active in-service program. Occasional vacancy hosp. owned appts. New Mexico licensure as professional nurse and U.S. citizenship (or Immigration Visa) required. Write or call collect: Mrs. Emily J. Tuttle, Dir. of Nursing, Presbyterian Hospital Center, 1012 Gold, S.E., Alberquerque, New Mexico. Phone 243-5611. 15-32-3

General Duty Staff Nurses for 215-bed General Hospital, 30-min. from New York City. All shifts, all services. Salary $4,800 to $5,200, depending on experience. Shift differential $540. Living quarters available. Apply: Director of Nursing, General Hospital, Yonkers ,New York. 15-33-7A

Graduate Nurses for 450-bed non-sectarian acute General Hospital with NLN fully accredited school of nursing. Liberal personnel policies include tuition aid for study at Western Reserve University. Opening of new main building has created attractive positions for Staff Nurses in medical, surgical, obstetrics and pediatric divisions. Apartments available in immediate neighborhood. Apply: Miss Louise Harrison, Director of Nursing Service, Mount Sinai Hospital, 1800 East 105th Street, Cleveland 6, Ohio. 15-36-1D

Staff Nurses for modern 400-bed tuberculosis hospital, suburban Cleveland, Ohio. Monthly salaries start at $410 with semi-annual increments. Extra for night and relief duty, 5-day work wk., 3-wk. paid vacation, 6 paid holidays, liberal sick leave, comfortable accommodation in nurses' residence at low rate. Learn and earn at a progressive accredited hospital in a growing community. Write: Director of Nursing, Sunny Acres Hospital, Cleveland 22, Ohio. 15-36-1E

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Offers opportunities for NURSES. Attractive new building of 750-beds with on interesting variety of experience.

For further particulars write to:

THE DIRECTOR OF NURSING,
The Montreal General Hospital,
1650 Cedar Avenue, Montreal 25, P.Q.

ASSISTANT DIRECTOR OF NURSING

required for

A 163-bed
General Hospital

Please reply to:

Director of Nursing,
KIRKLAND and DISTRICT
HOSPITAL,
Kirkland Lake, Ontario.

PORT COLBORNE GENERAL HOSPITAL

PORT COLBORNE, ONTARIO

requires

REGISTERED NURSES

For recently expanded General Hospital of 166-beds within easy driving distance of American and Canadian metropolitan centres. Salary $335 per month with five annual increments of $120 per year. Consideration given for previous experience obtained in Canada. Accommodation available in nearly completed apartment residence, on hospital property, facing the lake.

Apply:

DIRECTOR OF NURSING,
General Hospital,
Port Colborne, Ontario.

U.S.A.

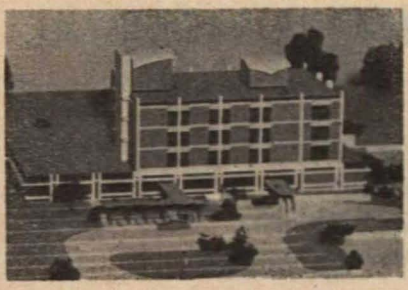
Registered Nurse (Scenic Oregon vacation playground, skiing, swimming, boating & cultural events) for 295-bed teaching unit on campus of University of Oregon medical school. Salary starts at $411/m. Pay differential for nights & evenings. Liberal policy for advancement, vacations, sick leave, holidays. Apply: Multnomah Hospital, Portland, Oregon. 97201. 15-38-1

Staff Nurses, University of Washington 320-bed modern, expanding Teaching and Research Hospital located on campus, offers you an opportunity to join the staff in one of the following specialties: Clinical Research, Premature Center, Open Heart Surgery, Physical Medicine, Orthopedics, Neuro-surgery, Adult and Child Psychiatry in addition to the General Services. Salary: $400-$462. Unique benefit program includes free University courses after six months. For information on opportunities write to: Mrs. Ruth Fine, Director of Nursing Services, University Hospital, 1959 Pacific Avenue, Seattle, Washington. 15-48-2D

Registered Nurses in a small community hospital with rapidly expanding services. Accredited by Joint Commission Hospital Accreditation. Salary meets American Nurses' Association scale. Travel time 60 minutes from metropolitan area. Inquire: Director of Nurses, St. Croix Falls Hospital, St. Croix Falls, Wisconsin. 15-50-1

ONTARIO

PUBLIC HEALTH NURSE required by the Ontario County Health Unit (Southern Area), close to the City of Toronto. Salary $4,000 - $5,600 with annual increment and allowance for experience. Car required; monthly allowance for car expenses. Personnel policies include: 4 wk. vacation; Ontario Hospital Insurance; P.S.I.; Pension plan; Life Insurance and sick benefit. Apply to: Dr. Margaret Braund, Director, Box 580, Pickering, Ontario. 7-152-1



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AJAX, ONTARIO

110 BEDS

Nursing the patient as an individual

Opening — October 1964

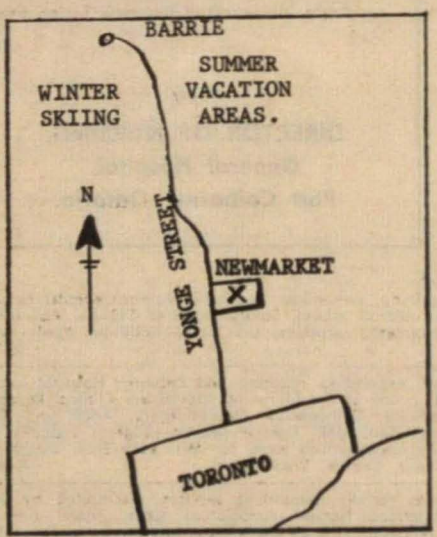
VACANCIES for O.R. Supervisor and O.R. Nurses. General Duty R.N.'s and Registered Nursing Assistants (Union Agreement for Registered Nursing Assistants) in Medicine and Surgery. O.R., O.B.S., Pediatrics. Salaries commensurate with prevailing salaries in Metro Toronto. Consideration for experience and education. Overseas nurses welcome. Personnel recognition and excellent fringe benefits. Professional developments fostered.

AJAX IS 7 MILES FROM METRO TORONTO, HOURLY BUS SERVICE

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ONE HOUR FROM DOWNTOWN TORONTO

260-bed Hospital with new facilities including:

INTENSIVE CARE UNIT
SELF CARE UNIT
PSYCHIATRIC UNIT

REGISTERED NURSES: $335-$400 per month

REGISTERED NURSING ASSISTANTS: $230-$265 per month

LIBERAL PERSONNEL BENEFITS INCLUDE:

Pension Plan, Group Life Insurance, Medical and Hospital Insurance, Residence accommodation available.

Please write for further details concerning employment opportunities to:

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THE WINNIPEG GENERAL HOSPITAL

is Recruiting General Duty Nurses for all Services

SEND APPLICATIONS DIRECTLY TO

THE PERSONNEL DIRECTOR, WINNIPEG GENERAL HOSPITAL
WINNIPEG 3, MANITOBA

MAIMONIDES HOSPITAL AND HOME FOR THE AGED

AN OPPORTUNITY
A CHALLENGE
A NEW EXPERIENCE

SUPERVISORS, STAFF NURSES, NURSING ASSISTANTS, INSTRUCTORS, PSYCHIATRIC NURSE:

We invite you to join the nursing staff of New Maimonides.

LIBERAL VACATION HEALTH AND PENSION PLANS SALARIES COMMENSURATE WITH ANPQ SCALE.

Apply to: **DIRECTOR OF NURSING,**
4373 ESPLANADE AVE., MONTREAL 18, P.Q.

GENERAL DUTY NURSES FOR ALL DEPARTMENTS

Gross salary for nurses registered in the Province of Ontario $335 monthly with annual increment $10 monthly to $385.

Salary until registration is established — $305 monthly.

Rotating periods of duty — 40 hour week, 8 statutory holidays annually — Annual vacation 21 days.

Annual sick time 12 days after one year, unused portion cumulative to 36 days.

Hospitals of Ontario Pension Plan.

Ontario Hospital Insurance and Physicians' Services Incorporated, 50% payment by hospital.

Apply:

DIRECTOR OF NURSING, GENERAL HOSPITAL, OSHAWA, ONTARIO.

THE SARNIA GENERAL HOSPITAL

Offers excellent opportunities for

REGISTERED NURSES AND REGISTERED NURSING ASSISTANTS

Sarnia is an industrial city located midway on the seaway, 60 miles north of Detroit and Windsor and 60 miles west of London. It is a resort area noted for swimming and boating as well as being located a reasonable distance from the skiing resorts in Northern Michigan.

The hospital is modern, fully approved (JCAH), and has recently been expanded to 350 beds.

Positions are available in all services.

Salary scale with annual increments to the maximum. Additional salary allowance for two years or more acceptable experience or postgraduate certificate. Benefits include pension plan, 40-hour week, regular rotation of shifts with premium pay for evenings and nights.

Apply:

PERSONNEL DIRECTOR,
SARNIA GENERAL HOSPITAL, SARNIA, ONTARIO.

ASSOCIATE DIRECTOR

SURGICAL NURSING SERVICE

THE UNIVERSITY HOSPITAL IN EDMONTON

requires

An Associate Director of Surgical Nursing Service to commence employment immediately. Applicant must be a registered nurse with postgraduate experience and training in surgical nursing. Preference will be given to applicants with degree or diploma in nursing administration or nursing service. Good salary and employment policies with wide range of fringe benefits.

Application to:

Dr. J. D. Wallace,
Executive Director,
UNIVERSITY HOSPITAL,
Edmonton, Alberta.

GENERAL HOSPITAL

ST. JOHN'S, NEWFOUNDLAND

Registered Nurses are urgently required for employment as:

ASSISTANTS HEAD NURSES FOR OPERATING ROOM

Salary on the Scale $3,600-120-$4,200 per annum.

STAFF NURSES FOR GENERAL DUTY

Salary is on the Scale $3,400-120-$4,200. A differential of $15 per month is paid for evening and night shifts in addition to the above scales. Attractive working conditions, including a five-day week; and statutory holidays and annual leave are granted.

Uniforms and laundering are provided without charge. The General is a 538-bed General Hospital offering all major services (except Obstetrics).

Applications and/or requests for further information should be forwarded to the:

DIRECTOR OF NURSES,
General Hospital,
St. John's, Newfoundland.

PROVINCE OF NEWFOUNDLAND

Department of Health requires for

COTTAGE HOSPITALS

(A) Charge Nurses — postgraduate experience required.

Salary scale $4,900-120-$5,800 per annum from which there will be a deduction for board and lodging.

(B) Assistant Head Nurses Salary scale $4,200-120-$5,000 per annum from which there will be a deduction for board and lodging.

Uniforms are provided without charge. Transportation for successful applicants, from outside the Province, is provided on the basis of a one year contract.

Cottage Hospitals vary in size from 12 to 67 beds and provide health services for the people of the outport areas of Newfoundland.

Applications and/or requests for further information should be forwarded to:

Director,
DEPARTMENTAL NURSING SERVICES,
Department of Health,
Confederation Building,
St. John's, Newfoundland,
Canada.

MONTREAL CHILDREN'S HOSPITAL

DID YOU KNOW THAT...

1. We have 354 beds for children from the Premature to the Adolescent age group?
2. Our nurses may be bilingual or English-speaking?
3. We are affiliated with McGill University?
4. We have an excellent Orientation and In-Service Program?
5. Salary is commensurate with experience and preparation?
6. We have vacancies for Registered Nurses?

For information please write:

THE DIRECTOR OF NURSING,
Montreal Children's Hospital, 2300 Tupper Street,
Montreal, Que.

DIRECTOR OF NURSING AND NURSING SUPERVISORS

Required for the Children's Services of the

VERDUN PROTESTANT HOSPITAL

This unit includes services for emotionally disturbed adolescents and the mentally retarded. A Director of Nursing for the services and supervisors are required. Preference will be given to senior personnel with university degrees or diplomas in teaching, administration and clinical supervision. Suitable candidates will also have teaching responsibilities.

Applications are invited from qualified persons who are interested in this field of service, and should be forwarded as soon as possible to:

VERDUN PROTESTANT HOSPITAL,
6875 LaSalle Boulevard, Verdun, P.Q., Canada.

SUPERVISOR — HEAD NURSE

required for 220-bed hospital with newly reorganized nursing service

EVENING AND NIGHT SUPERVISOR
HEAD NURSE FOR 25 BED PEDIATRIC UNIT

Preference given to those with university or post-basic preparation. Experience necessary. Salary commensurate with qualifications and experience.

For further information apply to:

Director of Nursing,
CORNWALL GENERAL HOSPITAL,
Cornwall, Ontario.

OAKVILLE-TRAFALGAR MEMORIAL HOSPITAL

OAKVILLE, ONTARIO

General Duty Nurses for all departments, also Operating Room Nurses required in modern 340-bed fully accredited hospital.
Oakville is a progressive community situated on Lake Ontario just twenty miles from the cities of Toronto and Hamilton. Excellent salaries and personnel policies. Further details will be furnished on request.

Apply to:

DIRECTOR OF NURSING,
Oakville-Trafalgar Memorial Hospital,
Oakville, Ontario.

ST. JOSEPH'S HOSPITAL

Hamilton, Ontario

A modern, progressive, 850-bed hospital, located in the centre of Ontario's Golden Horseshoe, has openings for:

1) **General Staff Nurses in all clinical areas.**

2) **Registered Nursing Assistants in all clinical areas.**

For further information write to:

THE DIRECTOR OF NURSING,
St. Joseph's Hospital,
Hamilton, Ontario.

GUELPH GENERAL HOSPITAL

Active — 200 Beds
Fully Accredited

requires

OPERATING ROOM SUPERVISOR
INSTRUCTOR FOR OPERATING ROOM
SCIENCE INSTRUCTOR
GENERAL STAFF NURSES
REGISTERED NURSING ASSISTANTS

Pleasant City of 38,000. One hour from Toronto via 401. Good Personnel Policies.

For further details apply to:

THE DIRECTOR OF NURSING,
General Hospital,
Guelph, Ontario.

PROVINCE OF NEWFOUNDLAND

Department of Health requires Nurses for

(A) St. John's — Applicants should possess certificate in Public Health Nursing.

Salary scale $3,600 - 120 - $4,200 per annum.

(B) Outports—Applicants should possess certificate in Public Health Nursing or have post-graduate training in Obstetrics.

Salary scale $4,500 - 120 - $5,300 per annum.

Uniform allowance is provided. A generalized programme is carried out by all Public Health Nurses.

Applications and/or requests for further information should be forwarded to:

Director,
DEPARTMENTAL NURSING SERVICES,
Department of Health,
Confederation Building,
St. John's, Newfoundland,
Canada.

REGISTERED NURSES

and

REGISTERED NURSING ASSISTANTS

for

375-bed accredited General Hospital. Registered Nurses salary range $325-$390 per month with consideration for contemporary experience or postgraduate courses.

Registered Nursing Assistants $230-$260 per month.

For further information write:

Director of Nursing,
METROPOLITAN GENERAL HOSPITAL,
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AVAILABLE

In all our Clinical Nursing Services and in the Operating Rooms. Salary commensurate with experience. Opportunities for promotion. Excellent fringe benefits including refund of tuition up to six points per semester.

For further information write:

Director, Nursing Service,
THE JOHNS HOPKINS HOSPITAL,
Baltimore, Maryland - 21205

ST. JOSEPH'S HOSPITAL

Toronto, Ontario

REGISTERED NURSES

AND

CERTIFIED NURSING ASSISTANTS

600-bed fully accredited hospital provides experience in Operating Room, Recovery Room, Intensive Care Unit, Pediatrics, Orthopedics, Obstetrics, General Surgery and Medicine.

Orientation and Active In-service program for all staff.

Salary is commensurate with preparation and experience.

Benefits include Pension Plan, Group Life Insurance, Sick Leave — 12 days after one year, Ontario Hospital Insurance — 50% payment by hospital.

Rotating Periods of duty — 40 hour week, 8 statutory holidays — annual vacation 3 weeks after one year.

Apply:

ASSISTANT DIRECTOR OF NURSING SERVICE,
ST. JOSEPH'S HOSPITAL,
30 The Queensway, Toronto 3, Ontario.

DIRECTOR OF NURSING

required for

METRO-CALGARY GENERAL HOSPITAL
(200 GENERAL SURGERY BEDS)

To be responsible for the staffing and organization of all nursing services and a well planned in-service education program.

Please send complete details of your qualifications, experience, education, age, salary expected and date available for employment. All replies will be treated in strict confidence. References will be required. Applications should be marked confidential.

Reply to:

THE BOARD, METRO-CALGARY AND RURAL GENERAL HOSPITAL DISTRICT,
c/-Glenmore Park Auxiliary Hospital, 66th Avenue and 14th Street S.W. Calgary, Alberta.

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We are offering you pioneer opportunities to become professional lady medical representatives to call on doctors and hospitals.
Our future detail-women must be registered nurses, able to drive and travel, be willing to work hard and have a pleasant, extrovert approach to the medical profession. A certain amount of gracious aggressiveness is necessary.
We are a leading international corporation engaged in the manufacture and distribution of ethical pharmaceutical products.
The selected candidates will start with an attractive salary, be provided with a company car and will enjoy the usual fringe benefits.

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Requires

CLINICAL INSTRUCTRESS — SURGICAL CLINICAL INSTRUCTRESS — GERIATRICS
EXCELLENT PERSONNEL POLICIES

For further information, write:

THE DIRECTOR OF NURSING,
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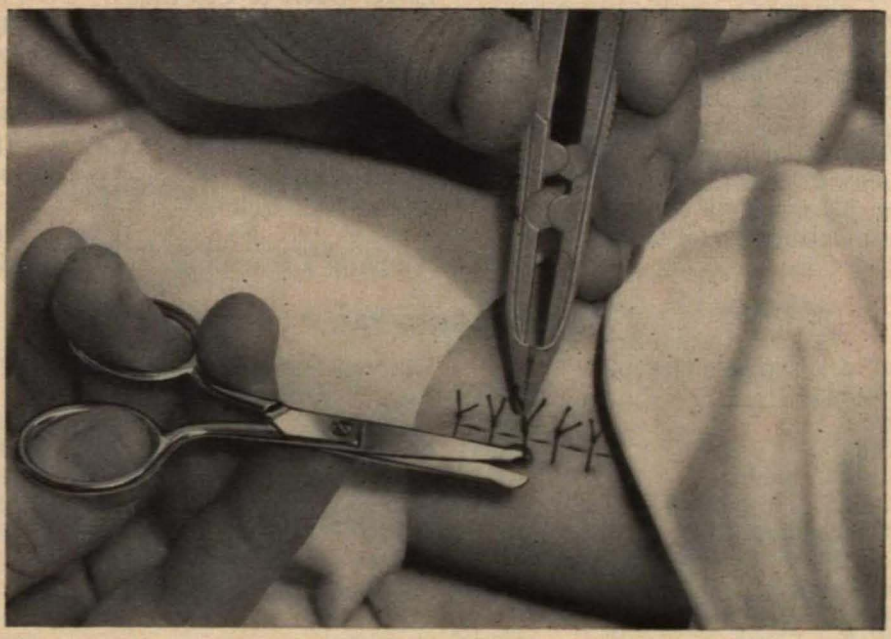
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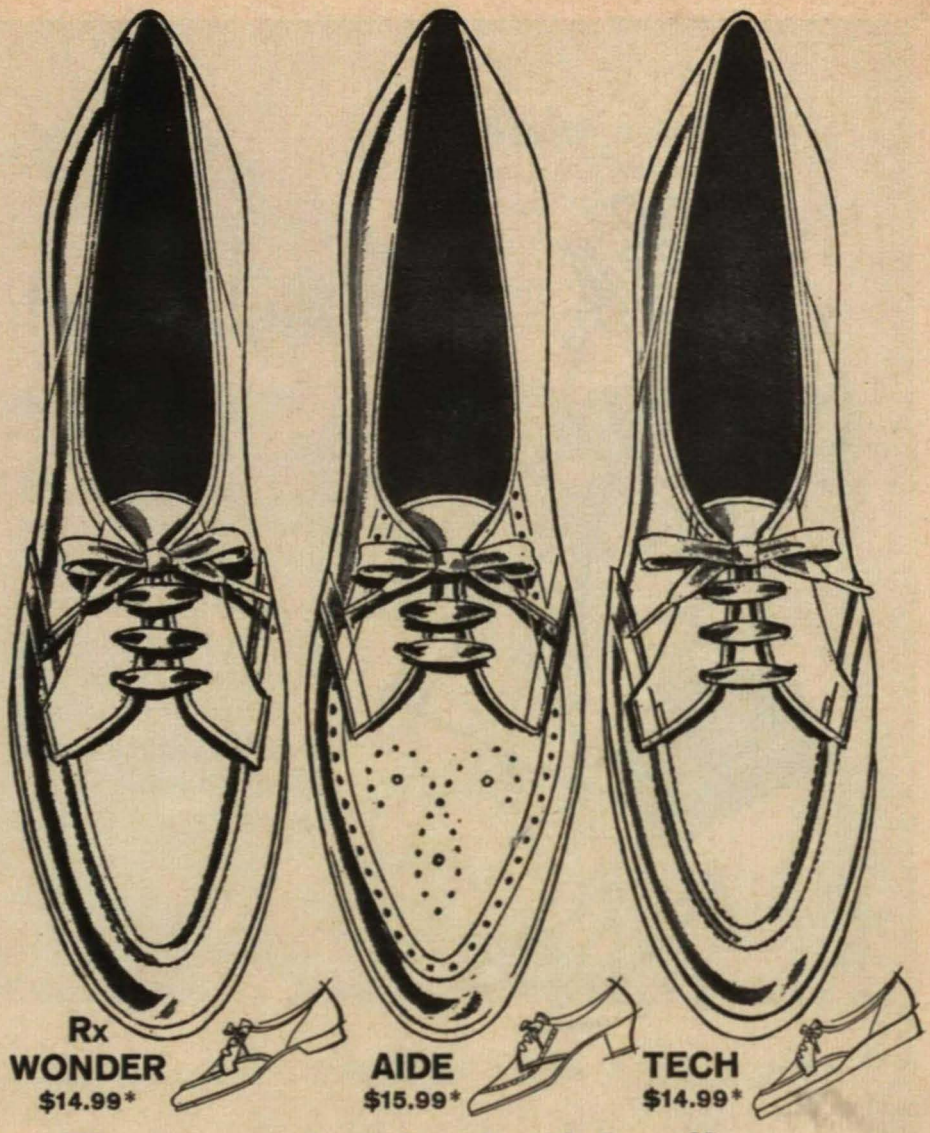
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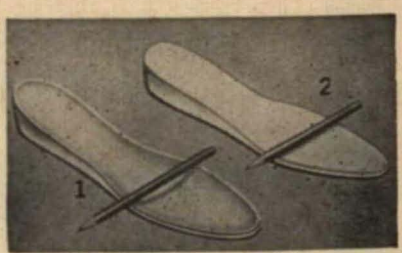


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